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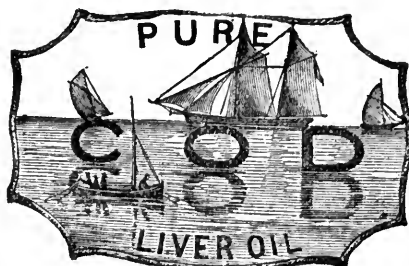
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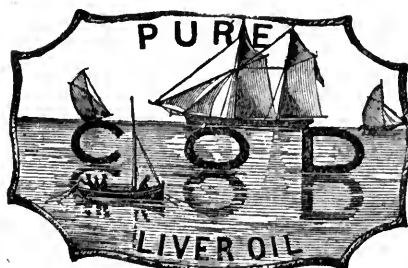
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"s, Silk Stockings, Trunks, Larynx, etc., etc.

act accord-

"Brevity, indeed, upon some occasions, is a real excellence."

—CICERO, BRUT. 13.50.

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# ARCHIVES OF DERMATOLOGY.

JANUARY, 1878.

*Original Communications.*

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## DERMATOLOGY IN AMERICA.

President's address delivered at the first annual meeting of the AMERICAN DERMATOLOGICAL ASSOCIATION at Niagara, September 4th, 1877,

BY JAMES C. WHITE, M.D.

GENTLEMEN :

After a brief meeting for organization at Philadelphia last summer, we assemble now for the first time prepared to present to each other our views in relation to the general interests of dermatology, to report and discuss the results of our special studies, and to form that more intimate personal acquaintanceship amongst ourselves, dermatologists of a wide country, which is so essential to mutual support and understanding. This meeting marks an important era in American dermatology—that of its fully recognized, independent position.

Let me briefly sketch the changes in its history within my personal experience during the last quarter century. So long ago it was I began the study of medicine in a school which, I may fairly say, has always been the first to recognize the ever progressive needs of medical education in general, as she was the first to establish an independent department of dermatology. At that time there was no special instruction given in this branch, either clinical, by text book, or lecture. All mention of the subject was of the briefest sort, as a matter of small consequence and little understood; and the occasional case seen in the clinical wards of the hospital was looked at more as an object of curiosity than of intelligent study. But a single English book on dermat-

ology was known to the student, one from its complex and cumbersome nomenclature, and its ever changing systems of classification, adapted only to impress him with the unconquerable difficulties of the study. Of the names of the older masters of the subject in France he had possibly heard mention, but nothing of their doctrines, and the modern German school, even then well started on the course which has carried it steadily onward to its present exalted position, was literally unknown. After three full years of constant attendance at school and hospital the student was graduated doctor of medicine, with the slightest acquaintance with the names of skin diseases, with no knowledge of the doctrines and principles of dermatology, and wholly ignorant of practical diagnosis and therapeutics. Yet this was no exception to the general plan of medical education in all our schools at that time; indeed, in nearly all others, the only organized instruction given during the year was comprised in four crowded months of lectures. Nowhere were there any special instructors,\* nowhere in the hospitals, even of our largest cities any special departments for the study and treatment of skin diseases, without which the former were well-nigh useless. The student of twenty-five years ago then, it may be truly said, knew almost nothing of dermatology when he became a physician.

And the profession which he joined: What was its state of knowledge in this respect? On the whole but little better. In the large cities there were not wanting those who had had in French hospitals abundant means of making themselves acquainted with the appearances of skin diseases, and had studied them as a part of their general education; there were even a few who were recognized as possessing an exceptional knowledge of them, and who made of them a special and even exclusive field of practice, but their knowledge was not availed of by the schools for purposes of instruction, nor by their professional brethren to any great extent in consultation. The great body of the profession had but a limited diagnostic acquaintance with cutaneous disease in its most common phases, and practiced a thoroughly routine and bald system of treatment. Of its pathology they knew nothing, but in its place cherished the crudest dogmas of unsupported medical opinion and popular prejudice. Of its literature they may be said to have known nothing beyond the works of Willan and Wilson. In such a state of knowledge but little was of course to be expected in the way of authorship; and in fact articles in the journals upon diseases of the skin, by those competent in any degree to discuss them, were very restricted in their scope and of rare occurrence. This brief and not flattering sketch of the state of dermatology amongst us only twenty years ago, although drawn from a necessarily limited field of observation, may, I think, be

\*I learn through DR. L. D. BULKLEY, that his father, lately deceased, delivered several courses of lectures on dermatology, between the years 1837-1854, at the schools of medicine in New York City.

fairly assumed to represent the whole extent of our country. What progress have we made since then?

At that time a few students after graduating at home began to find their way to the great Vienna school of medicine, then at the very height, not of its fame, but of its excellence; when its eminent teachers were still active, indefatigable even, in teaching. There they found a 'man teaching skin diseases as they had never been taught before, with unlimited means of clinical illustration, with the keenest eye for observation, with an unbounded amount of information drawn from many years of experience, with a self-restraint which no desire for premature fame could tempt into hasty publication, and with a sound and logical mind,' the chief of the German school of dermatology—PROF. HEBRA. Under his personal tuition they were taught to study diseases of the skin by the simple methods of observation which the naturalist employs upon objects of nature, and independently of artificial keys and systems of classifications. That they had so little to unlearn fitted them the better for the instruction they received. What they learned was: that skin diseases are like other diseases; that the cutaneous tissues are under the same laws of pathology as those of all other structures of the economy; that they are as free and independent in the exercise of these laws as the other organs of the body; that is, that their affections are as much local disturbances and unconnected with circulating fluids, organic functions, or intangible, theoretical vices as those of the latter; that the structural changes by which they are manifested, often temporary stages of progressive development, are no proper basis for the establishment of individual diseases; and that their successful management is based on the comparative results of all methods of treatment, empirical even it may be, conducted in a careful and impartial manner in extensive series of cases.

In the French capital of medicine they found abundant material for study, and teachers of ability, but a poor, because artificial, school of dermatology; elsewhere in Europe only a few isolated observers of merit in limited fields of research.

When they returned from these studies abroad they first fully comprehended that deplorable condition of dermatology at home which it became their duty to correct. But the means to accomplish this they had to create: a more general interest in the subject on the part of the profession, and opportunities through the established schools and clinics to instruct students; and progress in these labors was naturally very slow. By their writings and otherwise, they endeavored to establish the simple and scientific teachings of their master in place of the artificial and false theories so generally entertained here, and succeeded in gradually convincing a few of those most interested in the advancement of medical education of the importance of giving the student some instruction in skin diseases. The teaching was at first hardly recognized by the school, smuggled in, as it were, in some in-

stances under the protection of some professor ; then occasional short courses of special lectures were officially instituted ; later the title of summer or regular instructor was established ; and at last, professorships of dermatology were founded. The opportunities for clinical teaching were none the less slow in their creation. At first public dispensaries furnished some material for study mixed with a vast amount of general disease, but later, special out-patient departments for skin diseases were established in connection with these and the hospitals of the larger cities, and private dispensaries for their exclusive treatment were opened. All these furnish a large supply of cases which are at the service of the special instructors in the medical schools, but they are by no means sufficient for the full requirements of clinical instruction. They afford a vast amount of material from which a good selection for the proper illustration of the more common affections may be made, by which the student may acquire a ready knowledge of diagnosis and some acquaintance with methods of treatment. Used in direct connection with a complete course on dermatology, even such material is of great advantage ; but over it the instructor has at all times but slight control, and for the means of illustrating any lecture, in or out of course, he is wholly at the mercy of so uncertain an element as the weather. Under the most favorable circumstances, however, he is never able to keep his patients under that constant observation, which is necessary to teach the student the relations between the ever varying forms of efflorescences, and the different stages of multi-form diseases, or to properly study the therapeutics of dermatology by regulating the use and observing the immediate action of the remedies advised ; while the treatment in dispensary practice of some of the most serious affections is an impossibility.

With the gradual development of such opportunities for instruction under their persistent efforts in the various centres of medical education, and the acquisition from time to time of co-laborers animated with the same spirit, the present school of American dermatologists has brought its specialty from such beginning up to its present independent condition. With its growth they, too, have grown. Coming home from their pupilage overfilled, perhaps, with the personal views of their foreign masters, shining by a reflected light mainly at first, which was none the less valuable to make conspicuous the apathy which prevailed at home, they had yet to learn to digest the doctrines of others by the aid of personal observation, to reject what more mature judgment showed to be unsubstantiated, to retain what their own widening experience proved to be true. Even as lately as April 1871, in a review of "the progress of modern dermatology," I felt obliged to write as follows,—"Can we wonder, then, that America has as yet contributed little to dermatology, if our views concerning qualifications for authorship are correct : that it would be better if no man were allowed to write another book upon skin diseases, ex-



cept he had something to communicate new or better than what has already been said by others. This special fitness can be attained only by him who has had large and long continued opportunities for observing all the diseases about which he writes, who is thoroughly acquainted with recent advances in pathology, general and special, who is familiar with the opinions of other observers of all times and countries, and is able by the test of a wide experience to select the false from the true, so that error shall be no longer perpetuated. We have no work then to take its place as the representative of an American school. We have no book on general cutaneous medicine which is the work of a large observer, no monographs containing the researches of skilled and specially trained workers. We trust however, before long, to be able to welcome the beginning of a national literature of the right kind. Many young men have returned during the last few years, trained by study and observation under the best instructors in this department in other countries, and eager for work, who, if faithful to the methods acquired there and to the spirit of their teachers, will as opportunity and experience are afforded them, bring forth independent and reliable results worthy of their masters and honorable to our country. But observation and work must precede; and we cannot look for a national literature or school of dermatology until our dermatologists are made.'

I repeat these remarks for the purpose of showing how the promise they contained has been already in part satisfactorily fulfilled; how the earlier period of quiet work and observation has already ripened into a fruitful fertility. Well organized instruction in dermatology is now given by special teachers in most of the important medical schools of the country, and students have at least the opportunity of gaining a thorough and practical knowledge of skin diseases. Post-graduate courses and private instruction afford facilities of studying to the general practitioner even, almost as favorable as may be obtained abroad. The establishment of a special *Journal of Dermatology* under the successful management of our secretary with the assistance of sixteen collaborators in many parts of the country, has furnished such a channel of expression, and developed the preparation of original articles of such character as any nation might be proud to possess. It has also disseminated for the benefit of the profession at large, brief but full reports of the progress of dermatology in all parts of the world. Many other Journals also have shown how active in labor and accomplished are our members all over our wide country. I took the liberty, in view of the preparation of this address, of soliciting from all the physicians in the United States, known to me as especially interested in dermatology, a list of their writings upon subjects connected with dermatology, and I am happy here to acknowledge the universal promptness and courtesy with which the request was answered. The results of this enquiry, which will be of service in the preparation of a bibli-

ography for the Association, will be found appended to this address.\*

Among these many and valuable contributions to the literature of dermatology in our country, which include digests and reports of the progress in our department; expositions of the views of eminent dermatologists; translations of important articles by workers in other countries; reviews of authors; analyses of cases occurring in hospital, dispensary, and private practice; exhaustive communications upon rare forms of disease; more or less popular treatises on those of the most common occurrence; papers on the anatomy, nomenclature, classification, etiology, and therapeutics of cutaneous affections; reprints and translations of European writers; and original monographs of unsurpassed merit; we may congratulate ourselves that we have at last, also, most praiseworthy and complete works on general dermatology, and an excellent illustrated atlas by members of this association.

In the largest of our cities a society of the resident dermatologists for the purpose of mutual improvement has been in active operation for several years. The presentation of rare and doubtful cases and of valuable papers at its meetings with their consequent discussions, and the publication of its proceedings, have done much to advance the interests of our department among themselves and their less favored brethren elsewhere. Its success has conduced largely without doubt to the establishment of this, our national association. The want of some common meeting-ground for the dermatologists of all parts of our country has long been felt, and the call put forth at the session of the American Medical Association last year, by some of our most active members, for a meeting of organization at the International Medical Congress, at Philadelphia, last summer, met with general and cordial response. The character of the papers presented, and the interest shown in the discussions at the section of dermatology of the congress, was a most happy augury of the future success of the undertaking. Thus was our association founded, and we are now met as a body for the first time to test and strengthen the objects of its foundation. These objects, as they suggest themselves to your president are:

*First.* A more intimate personal acquaintanceship amongst American dermatologists. The little differences of opinion, personal jealousies, and even malicious criticisms, which are so apt to occur among physicians to the detriment of science, arise largely from mutual misunderstanding, and would be far less prevalent if the parties knew each other better. It is easier to express a harsh or ill-considered opinion of another, or of his works, if we do not know him, and do not take himself as an element, also to be considered in the formation of our judgment. There must be always differences of opinion amongst ourselves,

\* See page 14

differences arising from the natural and unavoidable constitution of individual minds, from the warping pressure of early and later education, from the various standpoints of our observation ; opinions which we are bound to respect as a part of the personality of colleagues, although legitimate matters of fair and open criticism, differences which we should try to reconcile in a common field of debate.

*Second.* Just such a meeting-ground for discussion is amongst our greatest needs. It is very evident not only to ourselves but to the profession at large, to our pupils, and even to our patients, that we, to whom they look for council, instruction, and assistance, do not agree upon many important questions relating to the nature and treatment of skin diseases. Some of us would refer the causation of nearly all these affections to chemical changes in the blood, others to disturbances in the functions of this or that organ, some to constitutional vices of mysterious character, others would make them a part of well known general diseases, some would explain their occurrence by external morbid agencies, others claim for them a local and more independent origin. So, too, in relation to treatment, some direct their efforts against the various general or special vices of the economy to which they attribute their existence, others to the secondary correction of any general disturbances which co-exist, but primarily to the restoration by local remedies of visible tissue changes. The student may hear in the various schools of our country, even in those of the same city, fundamental doctrines in dermatology as widely unlike as their respective origins are separated by century and country. Now until we can fully and freely discuss these and other differences of opinion in the presence of one another, can hear and fairly consider the data upon which those who hold such opinions rest, and are prepared to defend them, they will persist and multiply. Such differences of medical opinion, moreover, can be discussed, or possibly settled, only by those of extensive and mature experience. Questions of this nature cannot be decided by debate or vote in a large assembly of general practitioners, or in a special section of the same, when the only qualification of membership is the self-election of each individual to take part in its proceedings.\* It is for this reason that we would have this association, if it is to fulfill its highest mission, consist only of those who have already by education and experience proved themselves capable to discuss in a judicial way special questions of this character ; it should be held as a place of aspiration for those who take as yet but a partial interest, or have not done independent work in our department. By such mutual comparison of opposing opinions, in a spirit of earnest desire for the truth alone, with generous forbearance towards each other's errors, we may in time work out a common ground-work of belief and practice, which

\*Vide Transactions of International Med. Congress, at Philadelphia, 1876.

shall become the basis of a truly national school of dermatology.

*Third.* Another and most important object of the association should be the study of skin diseases as they occur upon this continent. Opinions have been expressed that marked variations from the European type in respect to comparative prevalence, reaction under treatment, and other features exist, and that they differ even amongst ourselves according to the point of observation. The wide ranges of diversity in climate, physical geography, modes of life, and nationality, which our broad continent presents, affords a most favorable field for such studies. A paper upon this subject containing results drawn from a comparison of as extensive series of cases of skin disease at home and abroad as could be collated from the most reliable observers, was presented to the International Medical Congress at Philadelphia.\* The home statistics were necessarily drawn from a restricted district, the great metropolitan cities of our Atlantic seaboard, and the conclusions warranted are accordingly diminished in value to a corresponding degree. They are of value, however, as the beginning of systematic work in this direction. As the number of special and competent observers increases, and shall be found to occupy more distant fields of study, we shall in time be able to collect such data as will enable us to determine in more definite form this interesting question of variation. In the meantime, the communications which each member should feel it his duty to present at our annual meetings, will naturally contain in great part the results of their observation of diseases remarkable for variety and for deviation from the accepted standard, or of these affections as they occur *en masse* in the large clinics of our great cities. It is none the less important that each one of us should keep a record of all cases of skin diseases in all parts of the country, however few they may be, that we may have a reliable and comprehensive census in process of formation. It might be well to establish a standing committee of the association, to which the collection of such data should be entrusted. In this division of our work will be included the consideration of questions which may become matters of national importance. Leprosy has been hovering about our borders for many years, has been introduced into the very heart of our country by the importation of stock from a people prone to the disease, has been, according to reliable report, prevailing to a limited degree within a restricted locality of our Southern States; all for many years; and yet we have seen no reason to fear that it would gain a serious hold upon us. We have regarded it as a disease so far removed from us by time or geographical position, that it did not concern us especially. But the history of its terrible progress in the Hawaiian Islands within the past few years, the growing intimacy of communication between them and us, and the immigration in enormous numbers

\* See Transactions, published 1877.

to the Pacific coast of a race with whom it is indigenous, make the establishment of a foothold of the disease upon our soil by no means improbable. The question of its possible contagiousness, lately revived by competent observers, and of its most effective management, as a part of state or international medicine, may demand before long our special attention. Certainly its immediate condition within our borders should be the subject of careful investigation.

*Fourth.* The establishment of a uniform and simple system of nomenclature is an important object of this society. Of the miserable confusion which now prevails in this respect, all the world over among dermatologists, there can be of course but one opinion. We lack even yet a common language of expression. Those of us who are engaged in teaching especially, feel the necessity of a reform, and I know of no better body or more practical means to accomplish it than this society. Let a competent committee prepare a plan, which in simplicity and comprehensiveness shall seem to them best adapted to meet the requirements of writer, teacher, and practitioner; let us after due deliberation and discussion adopt it as the official and fixed code of the American Dermatological Association, which we also individually agree to conform to under all circumstances, and we should soon see it universally employed by the profession in this country at least, I doubt not. As an exhaustive table of synonymy, and a key of interpretation which it would also constitute, it would be a most valuable contribution to the literature of dermatology. Without some such concerted and official effort, we shall never be rid of this great stumbling block to progress, which a veritable lode-stone, is built up largely of the repeated attempts which individuals have made to remove it. Let me commend this project to your immediate attention.

*Fifth.* Lastly, another high object of the association is to foster the general interests of dermatology in all its relations to the profession and the public. First, in connection with medical education. We should endeavor to create an influence which should secure instruction in our department by thoroughly competent men in all our schools of medicine, by men, where they can be obtained, whose whole study and practice are devoted to it. Fortunately but little remains to be done in this particular. The schools have been the first to recognize the claim of dermatology in this regard, and to furnish their students with the best opportunities of study at their command. Whereas hardly ten years ago, we had not a single officially recognized representative among the great body of medical instructors in the United States; we now have:

Professors, 4; Clinical Professors, 5; Instructors, 1; Lecturers, 6; Total, 16.  
 PROFESSORSHIPS: Vermont, Bellevue, Chicago, Harvard.

CLINICAL PROFESSORSHIPS: University of City of New York; College of Physicians and Surgeons; Long Island Hospital-College; University of Pennsylvania; Women's College of N. Y. Infirmary.

LECTURERS: Missouri Medical College; Detroit Medical College; University of Louisville; Baltimore College of Physicians and Surgeons; Medical College of Ohio; Albany.

INSTRUCTORS: Jefferson Medical College.

The chief obstacle to more complete instruction now is the want of proper means of clinical illustration, which leads up to the question of our relations to hospital management. We have already in our largest cities well established and supplied out-patient clinics, which furnish abundant material for exhibition specimens of the more common affections, but, as already stated, wholly insufficient to fulfill some of the most important purposes of clinical teaching. What we need is the foundation of separate hospitals, or better, the establishment of special departments or wards in those already well organized and endowed, for the study and treatment of skin diseases. As now managed nearly everywhere amongst us, these institutions refuse to a large class of sick persons the benefit of hospital residence either wholly, or offer them, if received, not, we may fairly say, the best medical skill it is in their power to procure. There is no class of affections, moreover, which gives rise to more bodily suffering or causes more mental distress through the personal disfigurement they occasion, none which more especially demands the daily attention of the skilled specialist to meet the ever fluctuating changes they so often present, and to superintend the treatment which cannot be properly administered elsewhere. Every day we see in the out-patient department and elsewhere cases which we know are requiring attention they will not, cannot receive at home, cases which without restraint and peculiar management last indefinitely and spread disease, cases which entail horrible consequences upon others; all of them sure of more rapid and certain recovery if they could receive such hospital care, some of them as surely doomed to years of misery and even speedy death, because they do not obtain it. Those who from love to their fellowmen or pity for their bodily woes have left large endowments for their care in sickness, they who make generous appropriation from the wealth of states and cities for the treatment of disease among the poorer classes of society, certainly have intended no such arbitrary distinctions. It is not they who have ordained that a fever and a fracture shall have the best chance of recovery by proper nursing and the most eminent professional attention,—while an inflammatory or destructive process of the integument shall be debarred from both.—There is neither reason nor justice in such action, and they who control the government of such institutions have much to answer for, for such unequal distribution of hospital charity. The defence sometimes offered: that they cannot nourish specialties, is a very narrow one; skin diseases form a large portion of the ordinary affections of mankind, and general hospitals are bound to provide proper accommodation and the best medical skill within their reach for the sake of justice and

humanity. On broader principles a hospital board which cannot rise above the petty jealousies of individuals or cliques, which in these days of wonderful advance in special medicine can see no wider field of usefulness than its antiquated divisions of medical and surgical service, with their restricted modern signification, offer; which fails to perceive its duty to develop means in every practical direction, for the advancement of progressive medical education, is open to the criticism of the profession at large and should receive it. Until such reform is effected we shall have in this country no hospitals worthy the name of general or great. Let it be our most constant endeavor to create the sentiment in the public and profession which shall make such a reproach no longer possible.

And our relations to the profession at large and to the public: are they what they should be in all respects? The hostility which at first existed against all specialties affected that of dermatology also, and has not yet wholly subsided. Physicians, who openly confess ignorance in all matters relating to skin diseases, and who would not venture to attempt the diagnosis and treatment of simple affections of the eye and ear for instance, do not hesitate to assume the care of every cutaneous disease which falls in their way. There is the disorder immediately before them, they can at least do no serious harm by their management of it, and such affections are not fatal, they reason. Moreover, they know so little of the advances made in modern dermatology, that they do not know how much more may be known by others than by themselves. Deeply rooted errors, too, with regard to the nature of some of the most common affections, and which form a large part of popular belief concerning cutaneous disease, still hold possession of the professional mind, or are made use of by some for selfish purposes. We constantly hear in our practice patients say that their family physician had advised them, often after ineffectual attempts to cure, that this or that chronic affection had better be let alone, that it would get well of itself, that it would not do to "drive it in," or that it might "strike in," and hint at possibly fatal results if it should be treated by the specialist. Such pandering to popular ignorance, or intentional perpetuation of error, cannot be too strongly condemned. Another popular belief is that the skin in some way serves as a mirror which reflects upon its surface visibly the disorders of the internal economy, and that 'humors' and other vices of the blood work their way outwards through the skin, and there express themselves in the form of various eruptions. The skin has thus lost its individual character in disease, and come to be held merely as a sort of index of the internal system; and the immediate conclusion of most persons with any affection of the skin is that 'the blood must be out-of-order, or that they have scrofula, or a 'humor.' What this last word means nobody knows, so that it may be disregarded as something which does not exist, but so far as concerns the

relation of the skin to the blood we recognise that it is an intimate one, as the blood flows freely through it, but no more intimate than that of the blood with all other structures of the body, and that as far as can be shown the condition of the blood has no more to do with the causation of skin diseases than of those of any other part of the economy. We recognise also the fact that the skin is of itself a great series of complex organs, with just the same inherent tendencies to disease and just the same right to its independent affections as the tissues of any other organ. By this we do not of course intend to deny that it is a part of and closely connected with the general economy, and sympathizes with the general condition of the body in disease; only no more so, necessarily, than any other of its separate parts. There is no more reason why we should not endeavor to cure any and every disease of the skin as of any other organ of the body, and no more danger is to be feared from our results, if successful. The combined evidence of all dermatologists of high standing is the same on this point. Another difficulty in the relations between the dermatologist and the general practitioner is the inability of the latter to comprehend the necessity of the constant personal attendance of the former in the successful treatment of many of the most common cutaneous affections. Even those who are ready to admit the superior knowledge of the specialist, and to avail themselves of his skill in the management of their patients in such cases, fail to understand why a consultation with him is so often followed by results so unsatisfactory. It is impossible in a disease like eczema, for instance, that we should be able to communicate in a single interview those principles of local therapeutics, which call for the simultaneous use upon various parts of the affected integument of as many different applications, in which the constantly occurring changes of this protean malady may necessitate change after change during its natural progress, and by which the properly selected remedies for to-day may become later either wholly inefficient or positively injurious. Yet I have known physicians practising among the most intelligent classes of society to base their opinion of the practical skill of the dermatologist upon the failure of immediate recovery in individual instances of such disease after one brief consultation, and to state with possibly innocent motives, when his aid was suggested in other cases, that the specialist had failed to cure in this and that instance of like character.—It is the same want of knowledge of the fundamental principles of treatment and pathology which instigate the frequent letters received by the dermatologist, asking for a few lines of advice in the management of some affection described simply by name, which often baffles his own skill acquired by years of special study and applied under direct daily observation. How unavailing are our best efforts under the most favorable conditions at times to gain the mastery over some of the most common forms of cutaneous disease, it is



our regret, not our shame, to confess. We may say without boasting that we prevent, control, and overcome the functional disturbances and tissue changes which constitute the diseases of the skin, perhaps more completely, however far short of our aim in this direction, than our brother specialists or the general practitioner those of the organs which they undertake to treat. Yet there is no class of affections which are so impatiently borne, none so difficult to keep under individual observation even in the highest classes of society, as those belonging to our special department of medicine. A patient with protracted fever or chronic pulmonary disease, for example, is content, family and friends also concurring, to remain for months, even years, under the care of the family physician in unquestioning submission to him and to the uncertain laws of disease. In our practice too few are found who are willing to follow implicitly for any such periods and under our constant observation the appropriate methods of treatment. Our patients mostly are able and prefer to consult us at our office, possibly because they act thus independently of the advice of the family physician in most cases, and therefore are but slightly under immediate control. They are at liberty to carry out at home the directions thus received, one half the success of which often depends upon the manner in which they are followed, and which may be irksome and disagreeable, as they best remember or please, and can obey our request to come at proper intervals or not, as they will. If the disease appears to improve, that is reason why they should not call, if it fails to recover after a period of trial in their judgment sufficient, that is reason not to call. Thus it happens that we are too often deprived of a fair opportunity of exercising our full skill, and that our reputation suffers most unjustly, thus that the average number of visits for each patient treated in comparison with that in general practice is ridiculously small and our income proportionately diminished. There is with us, moreover, but little opportunity for the exercise of that mechanical treatment which in other specialties and surgery commands such excessive rewards. These are the reasons why the exclusive practice of dermatology is more poorly paid than that in any other department of medicine, and why we should be justified in raising our fees for attendance to some proper and equalizing scale of compensation. To obtain a thorough knowledge of dermatology requires years of special study, to claim the position of a professed dermatologist demands, in justice to the profession at large, the relinquishment of all other practice, and the hope of the establishment of all those lasting family relations of friendship and authority, which are among the pleasantest rewards of the physicians life. Let not those therefore, who, tempted by the monied success of some specialties, would join our ranks with the expectation of an easier life or ampler rewards than are to be found in the practice of general medicine, do so without due consideration of the facts here presented.

I have thus endeavored to point out at the outset of our Association the directions in which its inherent energies should be guided, and the interests which should be its chief object to promote. Its formation may be regarded as the happy culmination of progress in a national dermatology of which we may well be proud, and as the completion of its established and independent position in American medicine. Let us cherish it warmly, serve it willingly and always, and make its future as sure as its present promise is bright.

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Favus in a cat, transmitted to a child, and from child to mother in the form of ringworm. American Practitioner, 1872.

Report on dermatology. Transactions of Kentucky State Medical Society, 1876-77.

Urticaria. Louisville Medical News, February, 1876.

Poison-oak eruption. Louisville Medical News, July, 1876.

Eight clinical lectures on dermatology. Louisville Medical News, Nos. 11-20, July, 1876.

## DERMATOLOGY IN AMERICA.

Address of the President at the first meeting of the NEW YORK  
DERMATOLOGICAL SOCIETY, May 18th, 1869.\*

BY THE LATE H. D. BULKLEY, M.D.

GENTLEMEN :

While I acknowledge with thanks the partiality which has led to my selection as the first presiding officer of an organization so happily inaugurated, the first of the kind in our country, I must congratulate you upon the favorable auspices under which it has been formed. It is very apparent that the branch of our profession which our Society is designed to cultivate is beginning to assert its claims for a better appreciation of its importance, and a more realizing sense of the large and promising field of labor which it presents. And, if any claim for notice can be predicated upon previous neglect, and immature and unsatisfactory ideas respecting it, even among the majority of those to whom we look with confidence for counsel and aid in other branches, the claim of cutaneous diseases for more careful and thorough study is among the strongest. We are not called upon to prove this want of definite and satisfactory knowledge on the part of our brethren. It is as voluntarily confessed as it is deeply regretted—and we may derive from this confession, and from the yearning which exists for a better state of things, a stimulus to zeal and industry in the course which we have marked out for ourselves in the association which has now been formed, and which I have now the pleasure to address. We may feel assured of the sympathy of our brethren in our labors, and that, if industriously and perseveringly continued, they will prove a benefit to our profession, and, in this way, to our fellow-men.

I deem it a matter of congratulation that, almost simultaneously with our enterprise, and in confirmation of the increasing interest felt in this branch of medical science, two other means of progress in the right direction are in immediate prospect—one of these, a larger and more available field of study, with increased facilities for investigation, in the establishment of a dispensary for these diseases†; the other, the announcement of a journal‡ in which the results of experience and observation can be recorded, and through which they can be disseminated, and thus increase our

\* This address, which has never appeared in print before, is given to our readers to make more complete the history of the rise and progress of Dermatology as a specialty in this country, dating back, as it does, many years prior to the commencement of the period considered by Dr. White in his address before the American Dermatological Association.—ED.

† New York Dispensary for Diseases of the Skin, incorporated July 20, 1869.

‡ *American Journal of Syphilography and Dermatology*, commenced January, 1870; now extinct.—ED.

means of doing good. And I think, too, that we may be pardoned for indulging in a certain measure of satisfaction that these three steps of progress in this branch of study have been taken almost simultaneously in our own country, and in our own city, and almost among our own circle—while our city can claim the honor of having had the first public institution \* for the special treatment of diseases of the skin, and the first course of instruction in them.

I will not enlarge upon the advantages which we may reasonably hope and expect from these combined means of improvement, nor will I detain you with even a glance at the present state of the knowledge of this class of diseases among us, or in other lands; nor will I dwell upon the incentives we have to improve these advantages. A brighter day has certainly dawned upon us, which I am thankful that I have been permitted to witness, and the light of which I trust will shine with increasing splendor long after my humble labors shall have come to an end—labors which had a feeble beginning, and were continued for years with but little companionship, and with the aid of no one to whom I could look up on the many occasions when we realize our weakness and our consequent want of counsel.

I need hardly say that when I studied my profession no regular instruction was given in this branch, and that it hardly received even a passing notice—so that it was rather a matter of accident that my attention was first specially directed to it. On reaching Paris, where I went in 1831 to pursue my professional studies, after graduation, the mere fact of the attendance of a young American friend at the Hôpital St. Louis, the then world-renowned field of labor of Bieth and Alibert, and the reputation of which still lasts, directed me to that institution, which I attended rather for the sake of gaining familiarity with the language than from any special interest in these diseases. About the same time I attended a course of clinical lectures on the subject, by Gibert, then a popular teacher in Paris—all of which, however, occupied but a few weeks of the months spent in Paris.

You can easily see, therefore, with what a slender stock of knowledge of these diseases I returned home, to enter the arena of general practice in this great metropolis. Slight and superficial, however, as this knowledge was, I found few, if any, who knew more about them than I did. Very soon after my return I entered the New York Dispensary, the oldest of these most useful institutions both for the public and the profession, and had the class of diseases of the skin assigned to me. Here I found at once a large field for observation, and one which had been but very imperfectly cultivated, and, availing myself of what little I had seen and read when abroad, here began my labors; and with even this slight advantage over my colleagues, and with a

\* "Broome Street Infirmary for Diseases of the Skin." Opened June 22d, 1836. Physicians, H. D. Bulkley, M.D., and John Watson, M.D.—Ed.

fair share of industry, I was soon able to point out matters of interest to which they were strangers, and which led them often to refer doubtful cases to me for diagnosis. As brother physicians and students began to multiply about me, the question was asked, perhaps with no very definite object, why I did not lecture on this subject. The idea had not occurred to me; but remembering that the best way to *learn* is to *teach*, I began to prepare myself for this, to me entirely new work, and in the year 1837 I gave lectures on Diseases of the Skin, the first, I believe, ever delivered in this country, at an institution established for the treatment of these diseases, known under the name of the "Broome Street Infirmary for Diseases of the Skin;" this had been opened during the previous year, and was the first organization for this special purpose, so far as I can learn, in this country—an institution which I had the pleasure of originating, and of helping to sustain. During the three following years these lectures were given at an institution which had its origin in this Infirmary, known under the name of the "Broome St. School of Medicine," in which lectures were also given on other branches of Medicine and Surgery. At the end of this time, after lecturing one year at the New York Dispensary I was invited to join in giving a Spring Course of Lectures at the College of Physicians and Surgeons, then located in Crosby Street, and more familiarly known as the Crosby St. College, in which connection I gave nine courses of lectures on Diseases of the Skin, during the following ten years, extending to 1851 inclusive. The succeeding year (1852) I gave a course of lectures, my fifteenth on this subject, at the University Medical College, the institution still known under that name, and now located in their new building in East 26th Street; and in 1854 gave my sixteenth and last course. During this period I contributed clinical lectures somewhat freely to different medical journals then in existence in our city, and since that time have only cultivated this branch in general practice.

I trust, gentlemen, that I shall be pardoned for thus dwelling on circumstances so almost entirely personal. My only apology must be that I could not otherwise establish the claim of our city for the first institution in our country for the special treatment of diseases of the skin, and for the first attempt to give clinical and other instruction on this important branch of professional study.

Since these times of the early, though feeble, attempts of your speaker at teaching by voice and by pen, which doubtless seem to young men, like most of those who now hear me, to belong almost to remote history, the subject of cutaneous pathology and therapeutics has undergone a great change. The microscope has thrown new light on many obscure points, the histology and pathology of the skin have been more minutely studied, talented and industrious men with large fields for observation have made them the subjects of study and of close investigation, the general progress of medical knowledge has shed light on their etiology, and

enlarged the stock of our remedial means—and I realize that this progress has left me far behind, and feel that I may well sit as a learner on many points at the feet of much younger friends, and shall consider myself almost as a beginner in the cultivation of the field which has been so long spread out before me, covered with the mist of confusion and uncertainty, upon which the light of science is now beginning to dawn. You must, therefore, excuse me if you do not find in me so active a collaborator as you might expect from one whom you have thus honored in calling to preside over you—an honor which I doubtless owe more to my labors in the past, than to what you can expect from me in the future. I am happy, however, in seeing so many around me in our city ready with zeal and talent to enter upon this field of so much interest and promise, and with advantages so greatly increased by the opportunity for associated effort which this organization will give, and for the interchange of ideas and observations which the proposed journal will afford. And to you, gentlemen, will the profession look, and to those who may become associated with you, for the improvement of these privileges, for which your opportunities and the present state of science make you responsible—for you must remember that privileges involve responsibilities, and these you are competent to meet and will not shrink from—and I doubt not that you will reap your reward in the pleasure which the acquisition of knowledge yields, and in the satisfaction of doing good, if not in a more tangible form.

I need not assure you of my best wishes for your success, and that the society so favorably organized, and with such fair prospects of usefulness, both as to its field and means of labor, and which now holds its first meeting, may prove an honor to our profession and to our country—and I feel that in such wishes our profession will cordially join.

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## AUTO-INOCULATION OF VEGETABLE PARASITES OF THE SKIN, AND THE CLINICAL TESTIMONY FOR THEIR IDENTITY OR NON-IDENTITY.\*

BY EDWARD WIGGLESWORTH, M. D.

**I**T was my original intention to place on record in this paper, certain auto-inoculations with the matter resulting from simple inflammation, made, in 1867, to test how far such inoculations would reproduce in successive generations ulcerations resembling those from the poison of chancroids. Pick, of Prague, had made, in 1865, at Zeissl's request, such inoculations upon syphilitic persons with positive results. My own experiments made also under Zeissl's supervision two years later, were upon a healthy subject, namely, myself, and gave also positive results.

\* Read by title before the American Dermatological Association, Sept. 4th, 1877.



These were seen by Zeissl, Hebra, Neumann, Kaposi, and many others and Kaposi subsequently confirmed my results by independent investigations of his own.

As however, Dr. Bumstead has very kindly already made public in his admirable paper upon the "Virus of Venereal Sores" (Trans. Internat. Med. Congress, Phila., 1876.) the sum and substance of the results of my experiments, it is useless to insert here what would be after all a simple reiteration of a plain statement of facts. I confine my remarks therefore to subsequent experiments with vegetable parasites.

Disease processes affecting the skin but not infecting the system and which though contagious, are purely local as to site, may best, be studied by auto-inoculation, and the greater the number of such experiments, the results of which are carefully observed and minutely recorded, the more numerous are our grounds for inference, both as to the nature of the process, and the best means for its destruction.

Every recorded experiment stimulates also new investigations. I have therefore felt justified in recording a few simple inoculations, such as may be performed by any one who has the opportunity, hoping that others may be inclined by the undertaking of similar experiments, and the recording of their results, to increase the number of preliminary data, thus furnishing better, because fuller opportunities for generalization in the direction of etiology, development, and therapy.

It is with the clinical effects of the action of the Mycoses, that we are at present concerned. A full consideration of the fungi, botanically considered, is not within the scope of this article; a mere bibliography of the papers on these subjects would exceed our limits. Botanists have as yet no distinct classification of the microscopic fungi in general. Still less are they in accord as to the class the members of which may attack the skin. It is even doubtful if these all belong to one class; or if they do, are they different species, or one species variously modified? If the last, then are these modifications constant under fixed conditions? Is there no miscegenation between different fungi? Individual or exceptional forms of growth hold very varying positions in the estimation of different botanists. Even supposing all forms of parasitic diseases of the skin to be due to one and the same parasite, and supposing all botanists to agree as to the identity of that fungus, yet the clinical difficulties as regards the effects of the presence of the Mycosis remain as before. Is this one fungus inoculable at all stages of its own growth upon every one? Is any one stage of its growth inoculable upon every one? Are the different stages of growth restricted in their inoculability to particular individuals? If so, will they infect his skin regardless of his existing condition of general health, and the peculiarities in the soil which he furnishes to the fungus? Will they affect every layer of his skin, and his skin equally in all parts of his body? Do they require

abraded or sound surfaces, and must they be inoculated in a particular manner, e. g., so as to enter a follicle, and is there a special duration of contact required, or a definite period of incubation? What influence is exerted by external attendant conditions, such as heat or cold, dryness or moisture?

The answers to such questions as these can only be determined by a great number of successful inoculations with definitely recognized results, these results, if from the same sources, and under the same conditions, being always identical and separated by well marked lines of demarcation from such results, invariably also identical among themselves, as arise from a different series of identical sources with their own unvarying attendant conditions.

The larger number of my experiments have given no definite results, and need not be alluded to. The inoculations have been made upon the uninjured integument, the abraded rete, the denuded corium, or within follicles; the fungus or the skin have been, one or both, either dry or moist; the methods have been by grafting infected hairs, by simply laying on the *materies morbi*, by rubbing it in or by pricking it in, and the contact has been temporary or permanent, the fungus in the latter case being covered by a watch crystal fastened to the skin by means of plaster strips; when thus applied, it was found that daily shower-baths could be taken without affecting the growth of the parasite.

This method furnishes retained heat and moisture from perspiration, while preventing removal of the applied material by friction, and obviating peripheral extension of the disease process.

Oct. 28th, 1871. A favus crust was removed from a patient and inserted under the skin, (slight bleeding) upon the inner aspect of the left forearm, about two inches below the bend of the elbow. Half an inch lower down, the epidermis was scraped away, exposing the papillæ, and another favus crust, powdered and moistened, was laid upon the places, and a watch crystal was fastened over these spots.

Oct. 29. The first crust is pushed out of the wound, and is adherent to the crystal. The wound is normal, a little bluish at the point of incision, and looks if it might suppurate slightly. The moistened powder is now a mass adhering well to the skin, dry at the edges and dark, somewhat fissured; in the centre, moist and of a lighter yellow color; a slight burning pain has been felt at intervals from the beginning. No areolæ nor signs of irritation. No itching except at edge of crystal from pressure.

Two little red spots are situated at a third and a half of an inch respectively, from the mass.

Oct. 31. The wound nearly well. The mass dry. The vesicles healed.

Nov. 1. New vesicles have now formed, one at each end of the incision of the first inoculation.

Nov. 2. The incision is healed, but over the skin, under which the crust had penetrated, the vesiculation is increasing and

becoming confluent around a hair, while close by, the lens shows a minute yellow spot.

Nov. 3. Vesicles around the incision are larger, their contents turbid. Vesiculation is beginning at one end of the inoculation upon the rete, where the crusted powder has now dried off. The watch crystal being removed, showed a crop of clear vesicles near its edge, due probably to mechanical irritation.

Nov. 4. All the vesicles disappearing, those at the edge of the glass being turbid.

Nov. 7. Everything normal.

The most marked results were obtained from another series to inoculations.

At the clinic of Dr. White, at the Massachusetts General Hospital on Nov. 2d, Dr. White exhibited a case of favus. Upon calling his attention to the yellow spot upon my arm, we both inoculated ourselves according to Köbner's method. Dr. White's positive results will be found in the Third Annual Report, (1872) of the Massachusetts State Board of Health, page 255. Upon my own arm in a fresh place, three hair follicles were dilated with a needle, and covered and powdered with moistened favus crust, (*Series A*). Two other follicles were inoculated, by working the powdered and moistened crust into them with the needle, (*Series B*). These spots were then covered by two small watch crystals. The crusts when dry, looked as if they were old ones already growing.

Nov. 3. Turgescence of the hair follicles, and a slight areola around each, gradually fading until Nov. 7.

Nov. 7. One of the first (three) inoculations, (*Series A.*) and both of the second (two) inoculations (*Series B.*) itch, and show a vesicle surrounding the hair follicle.

Nov. 8. Vesicles broken. Slight infiltration. No itching.

Nov. 9. Great exudation of serum. Hair follicle patent.

Nov. 10. Much more serum. Follicles cup-shaped, as if from loss of substance.

Nov. 11. Vesiculation, spreading peripherally. In centre, loss of epithelium in spots. So much serum that the sound epidermis is beginning to macerate.

Nov. 12. The vesiculation has ceased to spread. The points of inoculation are large shallow depressions from loss of epidermis, and are filled with yellowish-brown dry crusts of serum.

Nov. 13. The vesicular ring is shriveling. The central crusts dry and cracked. Watch crystal removed. Nothing more until Nov. 21. On the 18th the microscope showed a few grouped spores, or perhaps propagating cells, in the crust. The hair follicles somewhat eroded, and there were some whitish-yellow bunches around several of the hairs.

Nov. 21. The general vesiculation and irritation nearly gone. Small pustules around the hairs, on which the whitish-yellow bunches were, and these last now extend higher up the shafts of

the hairs, these having grown further out.

Nov. 22. Some itching. A strong lens shows a yellowish color, apparently extending deep into the hair follicles.

The whitish-yellow tubes around the hairs have now detached themselves from the follicles, and consist apparently of the epithelium of the follicles detached by the growth of the spores just as is the superficial horny epithelium covering the favus cups, by these last. This suggests that the cup shape of favus may be due to its growth within a follicle, the fungus being better nourished at the sides, or periphery of the follicle, which is now deprived of its lining epithelium, and growing less, of course, in the centre where it is poorly nourished. Moreover, the fungus extends peripherally where the soft tissues offer less resistance than the horny epidermis covering the follicle, which epidermis is, however, finally scaled off when the sides of the favus cup have pushed sufficiently upward to cut it off.

Nov. 27. Desquamation exposes four yellow nodules rising above the surface of the skin, and each pierced by a hair, giving a period of incubation of twenty-five (25) days. These nodules represent Nos. 1 and 3 *Series A*, and 1 and 2 *Series B*.

Nov. 29. Nos. 1 and 3 *A*, and 1 *B*, have scaled, leaving three well marked sulphur colored cups of favus.

Dec. 3. No. 2 *B*, has now become a cup in like manner.

Dec. 9. The cups have enlarged peripherally, the centres are less depressed and of a brownish-yellow, the later-formed periphery being sulphur-colored. The hairs in the centre of the cups are faded in lustre. Edges of older spots, dry, scurfy and detaching.

Dec. 10. The oldest cup No. 1 *B*, is now quite brown. No. 2 *B*, is extending into the sound skin, bright yellow, and pushing before it an areola, raised, but without scales.

Dec. 12. The areola of No. 2 *B*, has now faded, shrivelled, and cracked in centrifugal lines like radii.

Dec. 25. Cup No. 1 *B*, fallen to-day, leaves a red roughness of skin without loss of substance. No. 2 *B*, on the side toward the other inoculations is now brown and branny, like a corn cob, and semi-detached.

During the following night, cups Nos. 1 and 3 *A*, fell, leaving slightly infiltrated prominent red spots.

Dec. 27. Cup No. 2 *B*, fell, leaving a base like that of the others. During the succeeding week several small yellowish blisters appeared at intervals, on the sites of the pre-existing favus cups, dried in twenty-four to forty-eight hours to scabs, which then scaled off and showed the presence of spores. Skin then rapidly became normal.

Of special interest are the natural auto-inoculations, that is, those without my agency.

There appeared on Wednesday, Dec. 6, about an inch from the artificial inoculations, a clearly marked yellowish point smaller than a pin's head.

Dec. 7. The point is surrounded by a dark red, raised, circumscribed areola. Two fresh vesicles have appeared about half an inch from this point.

Dec. 8. Half of the point, and of its areola on the side towards the pre-existing cups, is covered by scales.

Dec. 9. The whole point and areola are scaling.

Dec. 10. Under the whitish scurf, the point is enlarging and turning yellow. The areola is flattening.

Dec. 11. One of the vesicles of Dec. 7, has dried to a scale under which may be seen the favus-color.

Dec. 12. Scale of Dec. 11 has fallen, leaving a favus cup. Duration of incubation is of course unknown.

Dec. 25. This last formed cup is finely grown. The yellowish point of Dec. 6th has disappeared.

Jany. 14. The cup of Dec. 25 has fallen off.

Jany. 25. A small pustule on the site of the cup which fell Jany. 16.

Jany. 30. Pustule has healed, leaving a slight reddish color.

Positive results were also obtained from inoculations made Dec. 26, upon three hair follicles, with the dry dust obtained from the crusts of Nos. 1 and 3, *Series A*, which fell during the night following Dec. 25. The dry dust was pricked into the hair follicles, and covered with a wet rag and plaster.

Jany. 2. Coverings removed, showing three reddish irregular circles, half the size of a gold dollar. The skin is puckered, as if vesiculation in its initiatory stage were present, and pale where partially raised. The hairs were loose in their follicles, but showed no mycelium or spores.

Jany. 5. One hair follicle quite patent, its tube-shaped epithelium protruding, and enveloping a hair, which is twisted and broken. Paleness of patches gone.

Jany. 7. Patches wine-colored, the whitish cylinder growing upwards upon the base of a faded hair and outside of the follicle.

Jany. 8. A yellowish color at the base of the hairs extending into the skin. Scaliness around the edge of one patch.

Jany. 9. The scaly patch of yesterday has become an unpointing pustule, surrounded by a branny swelling slightly reddened. No pain. Some itching. The other spots are beginning to scale.

Jany. 13. One scale detached. A favus cup is evident on its site. Examined microscopically, this showed spores and mycelium and it left, after removal, a depression or hole on the site of follicle. Incubation eighteen (18) days.

Jany. 15. Another scale detached, leaving another favus cup not rising above the level of the skin. Inoculation twenty (20) days.

Jany. 19. The third favus cup is evident. Incubation twenty-four (24) days.

Jany. 25 and 26. Cups all fallen. Slight pustulation, itching, scaliness, etc., as in former inoculations.

Mar. 1. Everything normal, except mere redness of skin, and that too without any treatment.

The scaliness in these cases was always distinct in appearance from the annular form of *tinea circinata*.

In the Dublin Journal of Medical Science, for May 1875, Dr. W. G. Smith states, that his own arm, and that of Dr. C. Ball, being inoculated with the *favus debris*, showed after eighteen days indubitable *favus cups*, but never any appearance of *tinea circinata*.

On Dec. 18, 1873, I experimented with the *Trichophyton*, by taking hairs and scales from the head of a neglected scrofulous child, who had four large well marked patches of *tinea tonsurans* with abundant fungous growth, and rubbing and pricking these when moistened into several hair follicles of my arm, and upon the skin denuded of epithelium. A watch crystal was fastened, by means of plaster strips upon its edges, over the spot.

Dec. 19 to 21. Slight redness, itching, exudation under the skin, raising of epidermis, and peripheral desquamation.

Dec. 22. The red spots slightly depressed, covered each by a horny scale at the point of insertion. The spots gradually faded, but the horny scales increased slightly in thickness and hardness, until Jan. 3, when they split open. The fissure widened upon Jan. 4.

Jan. 5. The fissures are wider still. Where the inoculation was made upon an excoriated surface, the horny scale has exfoliated; the epidermis is raised at the periphery of the patch, is dry and forms an irregular circle.

Jan. 18. Itching and gradual extension of the circle, with a raised border now well marked. Within the circle a diffused, dry scaliness.

Jan. 25. The circle is now nearly as large as a silver half-dime.

The circumference is raised sufficiently to be possibly vesicular. A smaller ring is enclosed within the outer one, where the epidermis covering a former smaller vesicular periphery has dried and detached itself. Within the smaller ring, scaliness, and in the very centre of all the skin shows a tendency to become normal again.

Feby. 8. Everything has by degrees returned to its normal condition, without treatment. My other experiments with the *trichophyton* have given no positive results.

Dr. George H. Rohé, of Baltimore, formerly my assistant at the Boston Dispensary for Skin Diseases, experimented also at my request, and kindly furnishes me with the following notes:

Oct. 5, 1877. Two inoculations were made upon the left arm, flexor surface, with scales from patches of both *tinea tonsurans* and *tinea circinata*.

Oct. 13. Itching at intervals.

Oct. 16. The patch has extended and measures 1 c-m in diameter. Border slightly raised and papular.

Oct. 15. Another inoculation with scales from *tinea circinata* was made upon the same arm, with material from the same case which furnished that for the first inoculation, treatment having been meanwhile pursued.

Oct. 19. The spot first inoculated with *tinea tonsurans* is  $\frac{1}{2}$  c-m in diameter, and has a number of hemp seed sized vesicles around its border. Slight itching.

The two *tinea circinata* inoculations show no signs of action.

Oct. 26. The vesicles of the patch have ruptured, and given place to moderately adherent, white, rather large scales. Itching has ceased. A microscopic examination with a  $\frac{1}{4}$  Spencer objective, showed numerous mycelia. On this day, another inoculation with scales from this patch.

Nov. 3. The appearance of the patch is that of a typical "Ringworm," oval,  $3 \times 3\frac{1}{2}$  c-m., slightly elevated border, slight scaliness, less redness, no itching. The microscope shows many spores, and beautiful mycelium. No action in last spot inoculated, nor in the two inoculated from *tinea circinata*.

With the microsporon furfur, I have never been able to obtain positive results. A few red points make their appearance, there is a slight pricking, and even some soreness, after which the skin rapidly resumes its normal condition. I have had no better success with the Soor fungus of *Oidium Albicans*, which vegetates in the middle and deeper layers of the mucous membrane of the mouth, pharynx, œsophagus and vagina, and, according to Dr. Steudener, (*Volkmann's Klin. Vorträge*) drives its mycelium strings even into the blood-vessels. Nor have Grawitz (*Virchow's Archiv. Vol. 70,*) and Brefeld (*Vorträge in der bot. Gescht. zu Berlin, 1876,*) and (*Würzt. Verhandl. 1873,*) been more successful, who uphold the identity of the Achorion, the Trichophyton, and the Microsporon, with the fungus of *Oidium lactis* ("*Mycoderma vini.*") Taken however, from the mouth of a child, and planted in a sort of Pasteur's solution, there cultivated until ripe, and then the pure conidien given in milk to young cats and dogs, the *Oidium lactis* did show itself, after the death of the animals, as apthous patches upon the pharynx, hard palate, tongue and even larynx, where a true abrasion was produced by the fungus.

The clinical observations of Hebra point also to an identity in these parasites. He would, however, consider the *Penicillium* as the common origin. This is the common cosmopolitan mould, occurring, according to Hallier, (*Pflanzlichen Parasiten, 1876,*) upon all decomposing vegetable substances. I have carefully cultivated this fungus upon moistened stale bread, and inoculated it in all stages of its growth, but without positive results.

The fungus of the parasitic form of Sycosis is the Trichophyton, and needs no further mention here. Those from Pellagra and Alopecia Areata have yet to prove that they exist at all. The Chionyphe Carteri, which causes in certain districts in India, the endemic disease Mycetoma, or Madura-foot (*Hirsch. Virch.*

*Arch. XX. VII. 98.*) cannot be regarded as a pure parasite of the skin.

The form of molluscum formerly called contagiosum, has no distinctive parasite, and its contagiousness is very doubtful; although a typical case of this disease, progressing, however, only to the stage of subcutaneous condyloma, did occur upon my own person, some months after expressing with my fingers, for the purpose of examination, some of the contents of a tubercle of molluscum.

There remains only that recently observed form of disease resembling modified vaccinia, called by Tilbury Fox, Impetigo Contagiosum. Fox, Kaposi, Duhring, Taylor, Piffard, Geber, Rohé, Leukowitch, Van Harlingen, and many others as well as myself, have observed, described, inoculated and examined microscopically, cases of this disease. Kaposi and Piffard alone have found a parasite, and it is questionable if this were not an abortive Trichophyton. Certainly as yet, this disease cannot be assigned to any definitely recognized causal fungus. That it is contagious however, there is no doubt. I inoculated myself, by various methods, about a dozen times at intervals. Nearly all the inoculations gave positive results.

At first there was either slight redness, itching or burning, or, in other cases, none of these. Then, usually in twenty-four hours, rarely longer, a vesicle would appear, which soon collapsed, drying again in from three days to a week, or less, to a thin yellowish crust, which turned brown, dried up, and fell off in a few days more. Instead of drying, the vesicles in a few cases became pustules with a slight areola. The crusts were very flat, umbilicated only when a hair passed through them, and rarely confluent.

Where the inoculation was by scarifying, the vesicles took on a linear form. Natural auto-inoculation also occurred. Thus, on Sept. 14, 1877, in the evening, I noticed three small vesicles upon a slightly itching surface, near the dry, straw-colored crust of a former inoculation.

Sept. 16, A. M. Two of these had aborted, but the third was a large well-formed bleb, its contents already slightly turbid.

Wednesday, Sept. 19. The bleb already drying up, but a fresh vesicle, self-inoculated, about half an inch off.

Thursday, Sept. 20. This last vesicle much larger and cloudy. Some itching.

Friday, Sept. 21. Still larger, crusting in centre.

While these two were running a normal course, the crust of the 14th developed a vesiculate circumference and an areola outside of this. The next day this vesiculation had shrunk away, and the site of the areola was now vesiculate, with a fresh areola around it, which last areola vesiculated upon the following day, the original crust in the centre of the patch having become during this time drier and drier. This peripheral extension suggested that of herpes iris.



In several cases, punctiform naevi were inoculated with the products of *Impetigo contagiosum*, and in one case a cure was thus obtained.

In many cases the serum, crusts, and hairs were examined by the microscope, but no parasite could be ever detected.

We see therefore that :—

I. All vegetable parasites of the skin are not inoculable at all times, and upon all persons.

II. Varying degrees of intensity, or duration of application, are needed for successful inoculation of different parasites upon the same skin, the severer cases requiring more thorough inoculation.

III. A healthy skin may resist the action of the less severe but more widely spread Mycoses, but yields to the more thorough inoculation of the more severe and rare forms, showing that the resistant power of the soil furnished is a factor to be regarded.

IV. Extension and intension are in inverse ratio to each other. The milder Mycoses are the more common, and point to an origin upon skins below par in vigor.

V. The various Mycoses of the human integument possess each its own distinguishing characteristics, although a transitory stage of growth of one of them may, in rare cases, as in the "Ring-worm stage" of *Favus*, simulate in appearance one of the forms, temporary or more permanent, of an apparently different species.

VI. While botanical and clinical observations are so at variance in reference to the identity or non-identity of the Mycoses, this question must be regarded as still undecided.

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## ON THE RELATION OF IMPETIGO HERPETIFORMIS TO PEMPHIGUS.\*

BY C. HEITZMANN, M.D.

**H**EBRA published in his great Atlas of Skin-diseases, Fasciculus IX, on plates 9 and 10, illustrations of a disease, which, up to the time of publication of that volume—1876—had been observed several times by others and considered but a variety of herpes. Hebra gives in the text, accompanying the plates, a number of reasons, why this disease should not be regarded as belonging to the group of herpes, namely : the eruptions never form vesicles or circles of vesicles ; they never run an acute or typical course ; they are not localized on certain parts of the skin, as are those of herpes ; but the disease appears in the shape of pustules, characterized by an arrangement in groups and a peripheral new formation, like the herpes iris and circinatus ; hence Hebra proposes the term *Impetigo herpetiformis* for this skin-disease.

\* Read before the American Dermatological Association, September 4th, 1877.

The essential features of *Impetigo herpetiformis* are : pustules arranged in groups or rings, which by drying turn into yellow, flat crusts, underneath which the skin is red, excoriated and moist, but not ulcerating. On the periphery of the primary eruptions new groups and rings of pustules form.

Hebra observed this disease five times only, on pregnant women, or shortly after delivery, and among those five cases, four ended fatally. I have seen in Vienna three of Hebra's cases, the pictures on Plate 9 and 10 of the Atlas having been made by myself after nature.

The course of this peculiar disease, Hebra says, has been almost alike in all cases. The anterior part of the trunk and the inside of the thighs were in each case the seats of the most numerous and largest circles of pustules, the centres of these circles being formed by greenish-yellow or brown crusts, or by an intensely red surface ; but other parts of the body, the upper extremities, the neck, the back, the thighs and legs, and even the face showed the characteristic groups and rings of pustules, around red or crusty centres, sometimes less developed, sometimes, and especially after a longer duration of the disease, marked by large rings of pustules and heavy central crusts. When lifting the crusts, there could be observed either a surface, covered already with epidermis, with an unusually brown-red pigmentation ; or there occurred the appearances of an *eczema rubrum madidans* of a high degree on a thickened, infiltrated, even exuberant ground ; or, finally, the red and moist surface was found to be coated by a yellow, pulpy, fetid layer. In no instance has there been observed a loss of substance due to ulceration.

After several weeks duration a spontaneous cure occurred on the places of first attack ; new eruptions arising in the meantime on parts of the skin formerly free from pustules. Among the five persons, subject to this disease, four showed these symptoms uninterruptedly up to the expiration of life, with a course varying in time between four weeks and three months. Only in one case, the last, which did not end fatally, there had occurred intermissions between the single eruptions, finally all ending in a complete cure.

Each eruption of pustules was preceded by a rigor, elevated pulse and temperature of skin, also by a great restlessness and sleeplessness, and, according to the more protracted or shorter intervals between the single eruptions, the fever was sometimes of a remittent, sometimes of an intermittent character.

As an essential feature of the disease it must be mentioned that it has been observed thus far only in pregnant women, or after delivery ; even in the latter instance the first eruption made its appearance during pregnancy. The delivery was premature in the four fatal cases, one of them being followed by a puerperal process ; in the latter case the pregnancy was accompanied by eclamptic seizures, the urine however being free from albumen.

In one case the mucous membrane of the tongue showed eruptions like those of the skin, namely: discs and rings from the size of a lentil to that of a penny, of a grayish-white color, the centres being slightly deepened; these eruptions left behind them after sloughing of the macerated epithelium covering, intensely red and excoriated surfaces.

Hebra's description is here quoted almost verbally, in order to show that we have to deal with a skin disease, so well defined in its characters and so different from analogous forms, that there has been the necessity of constructing a new name for it; although Hebra is known to be opposed to any new nomenclature of skin diseases.

It is worth while to mention that the disease, termed by Hebra *impetigo herpetiformis*, has been described in his book, together with *pemphigus*.

In my practice in New York city there occurred a case of *impetigo herpetiformis*, so peculiar in its features that I consider its publication as justified. Neither in Vienna, as I know from Hebra, nor elsewhere has there been observed, at least to my knowledge, a case of this disease since the publication above cited.

On August 24th, 1876, I was called in consultation at the residence of Mrs. S—y. with the attending physician Dr. Norde-man and the consulting physician Dr. Zinsser. The patient, æt. 52, a short but robust and well nourished woman, of rather uncommon intelligence, who had given birth to several healthy children, had had eczema on the neck during the previous year, which had been readily cured by Dr. Zinsser. Six weeks before I saw her, there had appeared sores in the mouth, which having been considered as syphilitic in nature, were treated with biniodide of mercury, of which preparation she had taken six or eight grains only. The first eruptions were relieved, but new ones came on, and an eruption of small pustules made its appearance on other parts of the body, which were thought to be eczema.

I found the lining mucous membrane of the lower lip, the gum, the cheeks and the tongue on the lateral parts, crowded with flat blisters, varying in size from that of a pin's head to that of a penny, partly confluent, partly coated with a grayish-yellow, epithelial layer, which on many places being torn away, left an intensely red, excoriated, easily bleeding surface; the gum was purplish-red, swollen, easily bleeding when touched. Speaking was almost impossible; there was also a considerable discharge of saliva, mixed with blood, as from mercurial salivation. The mucous membrane of the soft palate and throat was red and swollen, but free from any eruption; the right auricle was the seat of an eruption, also the skin of the neck on the right side to the diameter of 2"; the skin in the folds below both *mammæ* 4—5" diameter, and in both groins 3—4" diameter were excoriated, partly cicatrizing, partly dark red, infiltrated and thickened, as if seat of *eczema rubrum*.

On many places the periphery showed groups of small pustules,

best marked below both mammary glands. Accompanying symptoms : catarrh of conjunctiva and nose ; no fever ; menstruation ceased several years since in due time. No disease of the uterus ; never any complaint of genital troubles.

The diagnosis was impetigo herpetiformis, all the characteristic features being present.

New eruptions of blisters occurred on the mucous membrane of the oral cavity, including that of the tongue and the hard palate, never passing however beyond the soft palate ; each eruption was preceded by severe pains in the mouth, lasting 2 or 3 hours and a severe rigor. Such eruptions came on in a varying number every 3d, 4th, or 5th day, although after sloughing of the grayish epithelial layer, the excoriations healed up kindly under the free use of pitch-water, and astringent gargles. At the beginning of September, pustules appeared on the mucous membrane of the nose, accompanied by high fever and followed by erysipelas of the face.

The excoriations on the body yielded, though slowly, to local applications of zinc, diachylon, and tar ointments. New pustules, however, appeared on the external genitals, both labia majora and minora, and on the umbilicus. The healed up surfaces were either reddish-brown pigmented, or pale, grayish-blue, coated with a thick, exuberant, irregular epidermal layer. By the end of September almost all the sores on the body had healed, apparently greatly assisted by the tar-tincture ; the recurring eruptions of blisters in the mouth were less both in quality and quantity, and the patient had recovered so much that she could leave her bed, to which she had been confined several months.

On the 27th of September I observed first a collapsed bleb of the size of a penny in the left popliteal space, and on the 2nd of October, another one in the sacral region. About the middle of October suddenly, within two or three days, there appeared a great many pemphigus blebs on the abdomen, the back and the feet ; at the same time many blisters came on the inside of both lips ; these eruptions were associated with high fever, the pulse was weak and the patient apparently sinking. Up to the 22d of October, frequent vomiting took place ; on this day symptoms of œdema of the meninges came on : slow pulse, gnashing of teeth, then somnolence and afterward complete sopor and loss of consciousness, with continuous lateral rotations of the head ; camphor was given. No blebs formed during the last few days, and the excoriated parts of former blebs looked perfectly dry, and brown.

On the 26th of October, she awoke like a child from sleep, was very anxious about her health, and had no idea of the danger just passed. At the same time new blisters appeared in the mouth ; the sores on the body all increased in size and discharged a large amount of pus.

In the middle of November, new blebs of pemphigus appeared all over the body within two days ; the feet and hands became œdematous ; pulse 120, scarcely to be felt.

During December, under the use of large doses of quinine and local application of vaseline, as recommended by Dr. Zinsser, noticeable improvement had been obtained. Still the emaciation advanced, the pulse remained very weak, thread-like and interrupted; the face became œdematous, and the weakness advanced so much, that she could not move even her arms without the greatest difficulty and extreme pain; she then began to pass her urine and feces in bed.

Toward the end of December several bed-sores appeared on the back, and ascites was observed. The patient gradually sank, although the bed-sores healed up almost entirely, no blisters had formed in the mouth for two months, and new blebs occurred on the body only in a scanty number.

Toward the end of January, 1877, she had an attack of œdema of the meninges once more; she recovered again, and expired about the middle of February, under the symptoms of œdema of the brain. No post-mortem was allowed.

The case just described, in my opinion is of a considerable interest in several respects.

*First.* All the five cases under Hebra's care, in which the diagnosis impetigo herpetiformis was established, occurred in pregnant women; my case was the first observed during the climacteric years, independent of any disease of the genital organs.

*Second.* The diagnosis impetigo herpetiformis was fully legitimate for the first ten weeks of the disease; as the characteristic groups and circles of pustules could be watched, together with the formation of central excoriations and peripheral new formation of pustules.

*Third.* The formation of analogous eruptions on the mucous membrane of the mouth has been observed already by Hebra. As I have seen, there is not the slightest difference between the blisters as due to pemphigus and those, due to impetigo herpetiformis so far as the mucous lining of the oral cavity is concerned.

*Fourth.* The impetigo herpetiformis later changed its character into that of pemphigus; all the symptoms of the former turning into those of the latter on the skin only; while the eruptions in the mouth diminished from the moment of the appearance of pemphigus-blebs on the body; and during the last three months of life no eruptions formed in the mouth at all.

*Fifth.* The cause of neither pemphigus nor impetigo herpetiformis has been thus far elucidated; but my case, I think, gives full evidence, that both diseases arise from at least analogous, if not identical causes, and they have to be considered as being kindred to each other.

## A NOTE ON "DYSIDROSIS."

BY TILBURY FOX, M.D., LOND., F.R.C.P.

*Physician to the Department for Skin Diseases in University College Hospital, London.*

FOUR or five years ago, *i. e.*, in 1873, I contributed a paper on "Dysidrosis," to the defunct American Journal of Syphilography and Dermatology. Three years later, viz,—in 1876, Mr. Hutchinson for the first time drew attention to the same disease, which he termed Cheiro-Pompholyx. On seeing Mr. Hutchinson's contribution to the subject, I took occasion to point out that I had already described the same disease, and that Mr. Hutchinson had not done me justice in entirely ignoring what I had written on the subject. In the Archives of Dermatology, for July last, (and I desire to be allowed to take advantage of this opportunity to offer my congratulations upon the success and the great utility of this journal,) is a paper on this "Dysidrosis," from the pen of Dr. A. R. Robinson, in which, no doubt from the want of a proper acquaintance with all the facts of the case, he completely misrepresents the points that were at issue between Mr. Hutchinson and myself, and offers a number of remarks antagonistic to my views as to the nature of the disease, which remarks are based upon an erroneous estimate of dysidrosis as I have described it, and upon data obtained from a solitary case which I do not recognize as one of dysidrosis. I should therefore be glad to make some comments upon these two points.

I have no wish to re-open any controversy with Mr. Hutchinson as to priority of description, etc. We have both "had our say," and without any interruption of our friendly relation to one another; but I must put Dr. Robinson right as to the real ground of my complaint.

Not a line had appeared, as I have before stated, from the pen of Mr. Hutchinson, on the subject of cheiro-pompholyx, or "Dysidrosis" till the year 1876, nearly four years after my first article appeared, which Dr. Robinson himself styles "*the first article on this disease.*" Now how are questions of priority in research to be determined, by publication of the results of research, or by the *ipse dixit* of aspirants to claims of priority? Dr. Robinson states that Mr. Hutchinson taught and lectured about the disease many years before I published my first article. Does Dr. Robinson not suppose that I did the very same thing? I did not at once *rush* into print upon the subject. I observed many cases for a long time before I published anything about them. But neither Mr. Hutchinson nor I can claim anything upon the ground of our own assertions on this point. Mr. Hutchinson constantly published many contributions upon the subject of cutaneous diseases at different times, and he is not reticent

about new convictions or new observations. He did not say a word about cheiro-pompholyx till 1876. If actual publication be not taken as the real evidence of priority in research, then many just claims thereto will fail to be sustained.

But the question of mere priority is of little consequence. What I complained of was, that, while Mr. Hutchinson's attention had been specially called to my articles on dysidrosis before he published his illustrated paper in 1876, he ignored them. The facts are as follows, Dr. Robinson impels me to state them;—My junior, at University College Hospital, happening to be one day at one of the hospitals to which Mr. Hutchinson is attached, was asked by the latter gentlemen if he knew a disease attacking the hands, and characterized by the formation of vesicles and blebs of peculiar character, etc. He replied, "that it is evidently the same as that which we know so well at University College and which Dr. Tilbury Fox had described under the term "dysidrosis." Mr. Hutchinson's reply was that he must look up Dr. Fox' papers on the subject. When I heard of this conversation a few days after its occurrence, I at once wrote to Mr. Hutchinson about the matter. When his article on cheiro-pompholyx appeared in 1876, I was surprised to find that Mr. Hutchinson then made no reference whatever to my articles on "Dysidrosis." I wrote to him and he replied in a note dated April 16th, 1876, still in my possession, "Thanks for your note, etc. The fact is, I had quite intended to insert a note of reference to your description of dysidrosis, but being very dilatory and not having your papers at hand, I put it off and finally forgot it. I had asked N — long ago to get me your papers, but somehow it escaped us, and the fact is I have never yet seen them since you had asked me to read them, and owe you an apology for not having done so; but really the omission was very unintentional. I have been very much pressed with other work, and I wrote the description to that plate one evening in great haste, when the fasciculus was waiting. I had an impression that your dysidrosis was a name for obstruction of sweat ducts, and as I did not think that I should agree with you, I felt the less compelled to read your paper before publishing my plate," etc. Now the readers of the Archives will judge whether or not I was fairly dealt with, and whether I was justified in not permitting Mr. Hutchinson's publication to pass unnoticed; for his conduct implied a curious neglect of what had been written before on the subject, particularly after his attention had been specially directed to my papers before the printer had received anything from himself.

Dr. Robinson remarks that "Dr. Fox' description of the disease coincides very closely with that of Mr. Hutchinson, an occurrence not to be wondered at since the same patient furnished both of them the best example of the affection perhaps they had ever seen."

There is not a particle of truth in the latter part of this statement, for I specially referred in my work on skin diseases to the case, which subsequently formed the subject of Mr. Hutchinson's plate, in 1876, as an altogether exceptional example, a very severe phase of the disease; quite untypical and more like pemphigus than dysidrosis. My remarks fully implied this. But why does Dr. Robinson, in saying that my description coincides, etc., with that of Mr. Hutchinson's, reverse the sequence of facts? Mr. Hutchinson's description *followed* mine after an intermission of three or four years. It is Mr. Hutchinson's description that coincides with mine and not the reverse. The order which Dr. Robinson has adopted is calculated to raise in the minds of a careless reader the suspicion of plagiarism on my part.

In the next place, Dr. Robinson fails to perceive that if Mr. Hutchinson's account, and even his own, of the pathology of the disease be correct, there is nothing new in cheiro-pompholyx. Bullous conditions have been known and described for many a long year. It was because I did not believe the disease was a pemphigus or pompholyx of the hand, (cheiro-pompholyx) that I specially described it. If it consists *essentially* in an elevation of the cuticle by serous fluid in the formation of smaller and larger bullæ, then this is not a new or unknown condition, and, under the circumstances, Dr. Robinson's application of an old name for pemphigus, viz,—pompholyx, to the disease which is nothing more or less than a phase of pemphigus itself, is no great dermatological feat but a ridiculous proceeding. The only novelty connected with the whole matter is the idea that the disease begins anatomically in and about the sweat glands, and is attended with considerable inflammatory action of these parts, with excessive secretion of altered sweat, etc.

This last observation leads me to the consideration of the evidence which Dr. Robinson adduces in proof of the essentially non-glandular nature of dysidrosis, and of my, to him, absurd and silly errors in its clinical description.

Dr. Robinson's observations are based upon the data obtained from a solitary case, which I am quite unable to recognize as one of dysidrosis, but rather as pemphigoid in nature, as would seem also to be the case from the fact that pemphigus is hereditary in the patient's family—one of his children *having died from it*. Dr. Robinson also relied more on the patient's statements than upon his own observation, altogether so, as regards the phenomena of early attacks of the eruption; and when the case actually did come under Dr. Robinson's own cognizance, the disease had existed for three weeks already, all which circumstances tend to diminish the value to be attached to the phenomena observed by him, as evidences of the *primary* condition; for it is not uncommon for *secondary* conditions, such as eczema and bullæ to arise in cases of dysidrosis, which latter are no guide to the real phenomena of the typical and original morbid changes. Scant observations of this



kind upon a solitary case cannot be taken as outweighing in value the deliberate observation of others, extending over a period of years and to a large number of cases.

What I mean by dysidrosis, is a disease which, in its early stage, is anatomically seated in the sweat apparatus, which can clearly be made out to be so with the aid of a good lens. If the disease be not so seated, I decline to accept the diagnosis of dysidrosis ; otherwise the disease is usually an eczema, or pemphigus, or sudamina. The coexistence of malaria in many cases is strong confirmative evidence of its being connected with the sweat apparatus. I doubt not that many things not dysidrosis, are said to be that disease.

Though I do not accept Dr. Robinson's case as one of dysidrosis, as I have said before, similar morbid conditions to those which were present in Dr. Robinson's case, may be present as *secondary* phenomena in the disease. The inflammation may begin in the sweat glands, and ducts possibly, and then extend around and beyond, even to the papillary layer of the skin, whilst apparently the disease in the original seat subsides, and I doubt not that all trace of the early mischief may be lost. I have often seen simple vesications, the fluid of which must have escaped from the papillary layer, follow in dysidrosis. The shifting, by the spread of the diseased action from its typical anatomical seat to other parts of the skin, is not an uncommon occurrence in diseases of the skin, as in the bromide rash, acne, lupus, and eczema even, etc. Thus, the distinction between primary and secondary, or accidental and essential phenomena, is an important part to bear in mind in relation to all skin diseases ; and even if Dr. Robinson were to find the sweat glands apparently healthy in true dysidrosis, it would be no necessary proof that the disease did not begin in and about the sweat-apparatus. The absence of change must be established in the early stage of typical cases of dysidrosis, and of veritable dysidrosis only.

Another argument used by others, besides Dr. Robinson, to prove that dysidrosis is unconnected with the sweat apparatus is this,—that the secretion in the disease does not possess the reaction of sweat ; it is not acid, but alkaline or neutral. But sweat is not always acid. In my original account of the disease, I ought to have used the words altered sweat, for sweat, as I have subsequently done. But in dysidrosis, the sweat apparatus is inflamed, the sweat is altered, and mixed with inflammatory products, and is necessarily alkaline, and contains more or less albumen. Hence Dr. Robinson's criticisms upon this point, though they look very formidable on paper, are worthless as far as showing that the disease is unconnected with the sweat apparatus, because the secretion in it is alkaline or neutral. The comments of Dr. Robinson imply that I described merely hyperidrosis or sudamina, under the term dysidrosis,

Another error of Dr. Robinson is contained in the statement

that "the term hydroa has not yet been supposed to represent any special vesicular or bullous disease, but rather anomalous forms of pemphigus or herpes." Bazin, nevertheless, has given a most elaborate description of a disease which he terms *hydroa*, and one of his varieties he terms *hydroa-vesiculeux*, and another *hydroa-bulleux*. The term hydroa therefore has been definitely employed to designate a special and peculiar *vesiculo-bullous* eruption.

I did not quite like to let Dr. Robinson's paper pass without these few comments and objections, though they have been reluctantly made.

(The patient from whom the sections shown in Dr. Robinson's paper were taken, was seen by several dermatologists, also was exhibited before the New York Dermatological Society, and, as a number have agreed in recognizing the case as one of the "Dysidrosis" of Dr. Fox, it is very desirable that the real nature of the affection should be determined as far as possible. Dr. Robinson has promised a further communication on the subject, based on later studies in the disease, and it is hoped that Mr. Hutchinson will give a communication on the subject: also, that other dermatologists will observe and report on the disease.—EDITOR.)

## NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.\*

BY L. DUNCAN BULKLEY, A.M. M.D.

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XVIII. *Lupus*.—The subject of the local treatment of lupus needs to be approached with a great deal of caution; first, because of the very great importance of the right diagnosis of the disease; second, because local treatment alone is insufficient to cure it, that is, to prevent return or extension of the disease in new places; and third, because the local measures which are proper, must vary with the period of the eruption, with its extent, location, etc. In reference to the first point, I can only insist, that all that follows will be useless, or worse than useless, unless the diagnosis be correct; for many a time has it occurred that a tubercular syphilis or

\* These notes are intended to report, for the use of the general practitioner, the local measures in common use by the writer in the treatment of diseases of the skin, and which may be safely employed; it is not intended that they shall be exhaustive, nor that these measures are recommended to the exclusion of constitutional treatment; the formulæ are not claimed as original, although some of them may be. These "notes" are continued from pages 212 and 307, of Vol. II., and pages 24, 127, and 324, of Vol. III.

other lesion has been in vain submitted to the treatment of lupus. On the second point, the relative value of external and internal treatment, this is not the place to speak.

In regard to the local measures to be employed, they will vary very much not only with the extent and location of the eruption, but also with the object to be accomplished, and the stage of the disease, and also very greatly as to which variety of lupus is the object of attack. Three ends may be sought to be accomplished, namely,—a palliative, absorptive, or destructive. I will first speak of them with reference to the most superficial form of the disease, the lupus erythematosus.

The palliative treatment may be called for when it is desirable to rest alone on internal medication, in which case the hardness of the surface and occasional heat and burning is greatly relieved by means of the calamine wash, referred to in former portions of this serial, or a very weak oxide of zinc ointment, (gr. xv—xxx. ad  $\bar{3}$  j.), or simple osmoline, or even the cream of milk.

But the absorptive treatment is that most commonly called for in erythematous lupus, and one which will not infrequently be followed by success. This consists in the application of stimulant measures of greater or less severity, which do not directly destroy the tissue, and which form no eschar, except a superficial scaling or crusting, often not much greater than that of the disease itself. I have seen patches of the disease entirely disappear under the repeated painting or rubbing in of the liquor picis alkalinus in full strength, (℞ Picis liquidæ,  $\bar{3}$  ij, Potass. Causticæ,  $\bar{3}$  j, Aquæ,  $\bar{3}$  v, M.): after one or two applications the part becomes somewhat tender, and a crust is formed, which takes from four days to a week to fall, when the application may be renewed. A milder stimulant is the green soap, *sapo viridis*, dissolved in an equal weight of alcohol, with which the patches are well rubbed and allowed to dry, or it may be followed advantageously with a weak citrine ointment, (one part to two or three) or, an ointment of ammoniated mercury, ( $\bar{3}$  ss.— $\bar{3}$  j ad  $\bar{3}$  j). The soap lotion will sometimes be more efficacious with the addition of the oil of cade, made thus of equal parts of oil of cade, alcohol and green soap; or again, these may be too strong, and a weaker solution, or one made with water may be more serviceable. I have also seen good results from the repeated and continued application of the *emplastrum hydrargyri*, as recommended by Hebra.

It is sometimes necessary to resort to a real destructive treatment even in this superficial erythematous lupus, and that which is most certain is such as entirely removes the diseased tissue, and leaves a surface to heal by granulation. Such a means is afforded in the curette or sharp spoon, with which these patches are to be vigorously scraped, and it is even better to apply some such paste as that of chloride of zinc, or a strong solution of acetate of zinc to the scraped surface, to make the destruction more complete. I have seldom had occasion to use such severe measures in erythe-

matous lupus, and must refer to works on dermatology for further details. I have in one case successfully destroyed a patch of this disease by boring it well with a sharp stick of pure nitrate of silver, as will be described under the treatment of the ordinary lupus vulgaris.

In the treatment of lupus vulgaris the same ends are to be sought as in lupus erythematosus, namely, we may desire simply palliative applications, or may seek to induce absorption, or may attempt the destruction and removal of the diseased tissue. Very much may often be done in the way of starving out, as it were, the lupus growth, by means of agencies internal and external, which diminish its blood supply. Locally the application of very hot water on a cloth, every night, followed by some mild ointment, as bismuth sub-nitrate (3 ss. ad 3 j) will cause the disease masses to shrink, and to lose much of their congested character. The calamine lotion will also accomplish considerable.

But the cases are very rare where much permanent good can be gained by such measures, and resort must generally be had to those which by mild stimulation induce absorption, if it is desired to attempt something short of the destructive measures to be described later. Iodine in tincture, or in solution with glycerine and iodide of potassium, has long had a considerable reputation, but I have not so much confidence in it as some. When used it should be covered with gutta percha, or other impermeable dressing, to cause absorption, and by this means very considerable irritation can be produced. The mercurial plaster may also sometimes cause resolution of lupus tubercles, as also an ointment of the red iodide of mercury (gr. xv—3 j, ad 3 j.)

Most cases, however, fail to yield to anything but the most severe measures, and when this destructive treatment is once entered upon, it should be fearlessly and persistently carried out. The caustic which Hebra prefers is the solid stick of pure nitrate of silver, and this has yielded the very best results in my hands. When any amount of surface is to be operated upon, the patient should be under an anæsthetic, as the process is a terribly painful one. It will surprise anyone who has not experienced it to see how easily the tubercles of lupus break down, and may be bored into and thoroughly destroyed by a pointed stick of nitrate of silver, as prepared by Dr. Squibb. This is to be mounted in a proper holder (I fix a number of the sticks in quills previously) and is to be boldly thrust into each tubercle, and twisted and turned around until the entire mass is worked into a liquid pulp. There is no danger of going too far, simply because it is impossible to penetrate any but diseased tissue with such an implement. The only danger is in doing too little. The end of the stick may be worked around in each tubercle, and will be found to be arrested everywhere by the surrounding healthy tissue. As each mass is destroyed, picked lint is to be packed on, which adheres by means of the exuded fluid, and is allowed to dry on, forming a covering until it falls naturally in a week or ten days, when the surface beneath will

often be found completely healed. This process, of course, is not applicable to lupus of very large extent, nor to that which is increasing rapidly, because in the former case the shock from thus destroying a large surface is very great, and in either case the disease will make more rapid progress than the treatment can accomplish a cure. But even when the disease involves a large surface I have found this method serviceable in checking its advance in any one particular direction. I have arrested it as it encroached upon the eye, and also as it extended down from the wrist on to the back of the hand and fingers. The disfiguration from this means is less than from almost any other of the caustic treatments, and it is therefore especially suited to the removal of the disease from the face and hands.

The galvano-caustic treatment has generally given good results, but there is danger of destroying too much with it, for the hot implement will penetrate the healthy tissues as well as diseased. The curette or dermal gouge, a spoon-like steel instrument, whose round or oval bowl is about quarter of an inch long, with sharp cutting edges, is very serviceable in mechanically removing masses of lupus, but it is seldom sufficient to scrape them out alone. Some caustic should be applied to the surface to complete the work, such as chloride or acetate of zinc, or the nitrate of silver stick.

The external application of very strong solutions of nitrate of silver (3 ss.—3 jv, ad ̄j) brushed over or rubbed on to patches of lupus of larger extent, will sometimes suffice to remove the disease. This is of course to be repeated each time when the resulting crust or scale comes off, until the surface is healthy. Sometimes it is of advantage to combine this plan with that of the boring with the stick, that is, to attack the larger tubercles with the solid nitrate of silver, and brush over the intervening surface with a strong solution of the same, or to apply it to a surface which has been bored out, to render the cure complete.

I have not much experience in the use of other measures than those just spoken of. Indeed, I prefer the nitrate of silver treatment to all other external measures. Arsenic is used locally by many. It is painful, but has the advantage of destroying only the diseased tissue. Hebra advises the following formula:  $\mathcal{R}$  Acidi arseniosi, gr. x, Hydrag. sulph. rub. 3 ss., Unguent. Aquæ Rosæ, ̄j ss. M; the ointment is applied fresh every day, for three days, on bits of cloth, when it is removed, and the sloughs allowed to separate, and the surfaces to heal. If there still remains lupus tissue, the process is repeated. The French recommend highly very strong ointments of the red iodide of mercury, even made of equal parts of the mineral and lard. This destroys the tissue quite deeply, and when the crust falls is to be repeated as required until healthy granulations arise. Many other caustics have been employed with success, their mention would occupy too much space here. Caustic potassa is highly prized by many, but should be used with caution, as it destroys with great power even healthy tissues.

(TO BE CONTINUED.)

## Clinical Reports

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*Clinical Conversations on Diseases of the Skin.* \* BY THE EDITOR.  
*Reported by Robert Campbell, M. D., Clinical Assistant.*

CASE I. *Double herpes zoster.* The eruption of herpes zoster, zona or "the shingles," so constantly appears on one side of the body alone that it is a common remark that if it encircles the body it will prove fatal; while this latter is wholly untrue, it is still of the rarest occurrence that a complete belt or zone of the eruption is seen at the same level, and at the present moment I do not remember having ever met with it. But it is not very uncommon to meet with a double zoster, that is two eruptions of the disease, either on the same or on different sides of the body at the same time, and if this is borne in mind and the peculiar and almost pathognomonic characteristics of the eruption well remembered there should seldom, if ever, be any difficulty in the diagnosis; the case before us illustrates well these points.

This woman, Mary K., aged 54 years, first noticed a slight eruption on the left side about a week ago; it was preceded by pain in the regions about to be affected, which she probably, as most patients do, called a neuralgia. And such indeed it was, and you will understand this disease much better if you will always bear in mind its neuralgic element, or, rather, consider the affection a neurosis, nerve inflammation, of which the disorder on the skin is but an epi-phenomenon; for I need hardly remind you that post-mortem examinations have demonstrated that the real pathological lesion consists in an inflammation of the posterior, or sensory root of the spinal nerves, or, in the case of surgical injury, of an inflammation of the nerves themselves.

This patient now has, as you see, a band of vesicles, with some intermediate redness, extending around the left side at the level of the tenth rib, from the spinal column to the median line in front; and on the right side, at the level of the eighth dorsal vertebra is

\* Cases shown and remarks made to private classes, at the Demilt Dispensary, New York.

another band presenting the same features, reaching around just beneath the right mamma to the median line. Both of these bands or zones of eruption present much the same appearance, that is, they are composed of small, flattened vesicles grouped together in a manner which is quite peculiar to this eruption, and between these groups we have erythematous spots and some groups of papules, which are but the same eruption in an aborted state. You notice that all the elements of eruption in each band are situated within a region which is innervated by one or two intercostal nerves, this mode of distribution being so dependent upon the pathology of the affection that it is almost pathognomonic; the only exception to this, seen in the present case, is this group of vesicles about two or three inches below the umbilicus, which appear almost as if unconnected with the other eruption, but the elements of it correspond exactly to the rest of the eruption and there is no question as to its nature, although I am unable to explain its mode of development, it is altogether exceptional, but is an exception which it may be well to remember.

Herpes zoster in persons past fifty years of age may at times prove very serious, in the very severe and sometimes intractable neuralgia which accompanies or follows them; sometimes also, the eruption may in itself give rise to a great deal of trouble by ulcerating, or giving rise to carbuncles. I have recently had a case in private practice, where an elderly gentleman had a severe zoster of the right side of the neck and shoulder, in which a large amount of dermal inflammation resulted, with suppuration in the way of boils and almost carbuncles; the pain was very severe and necessitated the use of opiates.

I shall order this woman simply to dust the parts thoroughly with powdered starch, to dust also a wide bandage with the same, and then to apply it closely around the body, sewing it on in such a way as to make a firm covering over all the affected surface, over which the clothing will slide, allowing the inflamed tissues to heal. She does not complain of the pain, and I think nothing more will be required, and that one week from to-day you will see all of this surface free from acute symptoms, with all the intermediate erythema gone and these vesicles dried down into dark, flat, firmly-adherent scabs. The relief to the feelings afforded by this protective treatment is very great.

Case II.—*Scrofuloderma*. By scrofuloderma I do not understand lupus, although that disease has undoubted scrofulous affinities and is described by some under this name. This boy John Timmins, aged 13, exhibits in a most excellent manner one of the forms of skin lesion which I would name and recognize as scrofuloderma; that is, a suppurative dermatitis, of extreme indolence, giving but little pain, and attended with loss of tissues and consequent cicatrization. In many respects this eruption resembles both syphilis and lupus, but a little careful observation will enable you to determine that it is neither of these, but that the lesion on

the skin is simply one which corresponds to the tuberculous deposits in the lungs of these patients, or in other words, is an alteration in the skin texture which is dependent upon a depraved nutrition the total of whose expressions we call the scrofulous habit, or state.

The existing lesions may be thus described : on the lower extremities mainly, are a number, five or six ulcerating masses, covered with rather prominent crusts of a very dirty appearance, beneath which pus can be made to exude on pressure. These masses of diseased tissue vary in size from one-half to one inch in diameter, of irregular shape, with but slightly prominent edges and with almost no infiltration in the dark red indolent borders, which are hardly at all raised above the skin level ; on this one, where the crust has been removed, you see a rather even base, with sluggish granulations, secreting pus profusely. There is no pain, even when handled, and the ulcerations are extremely slow in their progress ; most of them are situated on the left leg, and several above the knee, principally because here the exciting causes of injury, etc., are most active ; there are one or two on the left leg and one on the arm, but none on the body.

But even more striking than the sores themselves are these cicatrices of a former eruption, of which there are a number, smooth, pale and supple ; several of which have resulted within the last three or four months, that is, shortly after he was here some months ago, and this here occurred under the internal use of cod-liver oil alone ; he has neglected treatment for a while and the present crop is mainly a new development. His general condition indicates his disease habit, you see how pale and anæmic he is, with light hair and eyes and prominent forehead, and that he has altogether such an appearance as one would be apt to designate as strumous.

Now this eruption might suggest to some the name *ecthyma* or *rupia* ; the former is attended with far more congestive phenomena and pain than appear here, and, moreover, would never leave such scars as these, while the latter term, *rupia*, has dropped from recent dermatological literature, or is applied only to forms of crusted syphilis, of itself it means nothing and has no pathological position. I do not regard the present eruption as one of syphilis, because of its multiple and scattered character, which is unusual for later forms which might resemble this, and the infiltrations in no way correspond to the tubercular or gummy syphilides, moreover certain of these healed up very promptly under cod-liver oil alone ; he has not the notched teeth, keratitis, or forehead of hereditary syphilis. Nor should you regard the lesions as *lupus*, although they resemble that disease in some respects ; *lupus* does not appear thus scattered in isolated spots, and situated as most of these are on the lower extremities, but generally attacks the face, which is here spared ; moreover, there are none of the tubercles which compose a *lupus* patch, nor any outlying ones, as



are so commonly seen, these separate ulcerations appear as if simply points or spots of broken down and suppurated tissue, with very little infiltration or surrounding congestion. Sometimes we see ulcerations almost as large as these in phthiriasis corporis, or from body lice, but these have no such cause, the boy is cleanly, and also the distribution of the eruption, largely on one leg is quite different from the ulcerations of phthiriasis which are apt to appear on the loins or back ; and seldom will you see such results, or indeed body lice at all, in children. I shall simply order him cod-liver oil, and am confident that the eruption will again yield and heal entirely if he is faithful to its use for a reasonable length of time.

## Society Transactions.

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### AMERICAN DERMATOLOGICAL ASSOCIATION.

REPORTED BY DR. L. DUNCAN BULKLEY, SECRETARY.

*First Annual Meeting, held at the Cataract House, Niagara Falls, New York,  
September 4th—6th, 1877.*

Present Drs. ATKINSON of Baltimore, BRODIE of Detroit, BULKLEY of New York, CAMPBELL of New York, DUHRING of Philadelphia, FOX of New York, HARDAWAY of St. Louis, HEITZMANN of New York, HYDE of Chicago, TAYLOR of New York, VAN HARLINGEN of Philadelphia, WHITE of Boston, WIGGLESWORTH of Boston, and YANDELL of Louisville.

The President, Dr. James C. White of Boston, in the chair.

#### FIRST DAY. MORNING SESSION.

**T**he Council presented a report of the work done by the officers in preparing for the present meeting. All the members of the Association had been communicated with in reference to the presentation of papers, and when all the titles had been sent in, their place upon the programme was decided by lot.

The Council had also invited a number of gentlemen in this country who were interested in Dermatology, to be present at the sessions of the Association, and a number of Dermatologists in other countries to take part in the exercises by their presence, or the presentation of papers. Responses were received from Professors Hebra, Sigmund, and Zeissl of Vienna, Köbner of Breslau, Profeta of Palermo, Italy, Englested of Copenhagen, Guibout of Paris, and Anderson of Glasgow, also from Drs. Güntz of Dresden, Tilbury Fox, Hilton Fagge and Dyce Duckworth of London. A written communication was received from Dr. Duckworth, and printed pamphlets from Drs. Sigmund, Zeissl, Köbner, Güntz and Profeta; a telegram of congratulation was received from Dr. Güntz just before the opening of the session.

The appointment of the Nominating Committee being next in order, Drs. Van Harlingen, Wigglesworth and Hardaway were chosen by ballot.

Drs. Atkinson and Brodie were appointed to audit the Treasurer's accounts.

The President then delivered his Annual Address, reviewing the progress of Dermatology in America during the past twenty-five years, and the gradual recognition of the branch in the Colleges of the Country.\*

\* Printed in full in this issue of Archives of Dermatology, page 1.

DR. BULKLEY moved a vote of thanks and the appointment of a committee to report in regard to the suggestions contained therein ; carried.

A paper by Dr. Brooks of Chicago, was then read, on

**“Acute conditions of disease excited by iodide of potassium.”**

When employed in unusually large quantities within a brief period he had found three symptoms to follow in a considerable proportion of cases, namely : fever, arthritis and iritis. These he considered quite distinct from the same manifestations of syphilis, and thought them gouty in character, this state being excited by the large doses of iodide. The remedy suggested was the employment of tincture of colchicum with calcined magnesia in purgative doses.

DR. TAYLOR had given  $\bar{3}$  jss. of iodide of potassium in the day, reached by increasing doses, without such manifestations.

DR. ATKINSON had seen nasal trouble from *gr. x-xv* three times daily, but had again seen  $\bar{3}$  ij taken thrice daily for a month by the same patient without unpleasant symptoms, after tolerance had once been attained.

DR. TAYLOR believed that if the remedy were increased slowly, much larger doses could be reached ; a combination of bromide of potassium with the iodide rendered the use of a less quantity of the latter possible. He had given as high as twenty drachms of iodide of potassium in a day to a patient with syphilitic sciatica.

DR. DUHRING regretted that no allusion had been made in the paper to the very important and well known effect which iodide of potassium may have in producing lesions on the skin. He mentioned a case presenting unusual features in a boy of 18, who had applied for the treatment of a patch of chronic eczema. There had developed a vesicular eruption, very acute in character, covering the backs of the hands and arms to such a degree, that they much resembled a case of confluent small pox. The vesicles were of a size from that of a large pin head to that of a large split pea ; there was no disposition to rupture, the contents remained clear from five to seven days, then became turbid and dried up. They occupied the extensor surfaces of the hands and fore-arms more than the flexor, and were very much more marked on the backs of the hands and sides of the fingers, than on the palms ; there was one large vesicle on the sole of the left foot, and others forming, some on the toes, and a few on the abdomen. The eruption on the hands resembled very much that of scabies, dysidrosis and confluent small pox ; he had never seen dysidrosis as severe as this, nor as severe as the cases of Dr. Fox. Dr. D. learned that the patient had been taking *grs. x* of iodide of potassium three times daily for three or four doses, the drug was stopped and the eruption began to disappear ; after a few days the iodide was given again, and the lesions reappeared ; he was then lost sight of.

DR. VAN HARLINGEN, who saw the case, added that the vesicles

were umbilicated, like those of small pox ; there was no fever, the pulse was normal ; the eruption affected principally the extensor surfaces, becoming more scattered as it extended up the arm.

DR. DUHRING, in response to a question, said that the lesions had a boiled "sago-grain" appearance, as though there was something within them other than serum ; when picked they did not collapse at once, but oozed slowly. He thought the term iodide of potassium eruption inappropriate, inasmuch as it signified very little, because various anatomical lesions can be produced by the drug, even on the same person.

DR. HYDE had given  $\bar{5}$  jss. of iodide of potassium three times daily for a week, in one case, he had never employed so large a dosage in any other case ; he had seen some of the effects described by Dr. Brooks, produced by small doses of iodide of potassium, in the beginning of its use, and alluded to the fact that after a small or moderate dose the iodide would produce the phenomena of coryza, etc., while large doses were occasionally well tolerated ; he had never seen any iritis which he could attribute to the drug. He thought that a careful distinction should be made between conditions occurring during the existence of disease, and those attributed to the medicine. In regard to the quantity of the iodide of potassium prescribed, he believed that Dr. Brooks occasionally gave as much as 1000 grs. in the day.

DR. TAYLOR has seen arthralgia produced by *grs. xv* given three times daily ; he recalled the erythematous condition on the face and hands following the use of even small doses, and questioned if the joint difficulty was not produced by a similar erythematous condition of the synovial membranes. He had never seen iritis dependent upon iodide of potassium, but had observed an aching pain through the sclerotic.

DR. HARDAWAY mentioned a case of tubercular meningitis where *iv-v grs.* of iodide of potassium given thrice daily produced an intense urticaria ; the dose was reduced, and even  $\frac{1}{2}$  *gr.* caused the reappearance of the urticaria ; the eruption had a purpuric tendency, the blood stains remaining several days.

DR. BULKLEY asked Dr. Duhring to give the reasons for excluding the so-called dysidrosis in the diagnosis of the case he had mentioned. The description Dr. D. had given answered so completely to that of Fox and Hutchinson, and to the appearances observed in a very severe case by Dr. A. R. Robinson and himself, that he should have regarded it as one of this disease ; this latter case was fully described by Dr. Robinson under the name pompholyx, with drawings of the microscopic appearances of sections, in the *Archives of Dermatology*, for July 1877, and need not be here detailed. In this, as in other cases, the eruption ran its course and reappeared again and again, and Dr. B. asked Dr. Duhring if the occurrence of the eruption at the time of the administration of the iodide might not be a coincidence, as the case had not been watched in its further development ? He himself had never seen

any eruption from iodide of potassium which at all resembled this. The time for adjournment having arrived, further discussion was deferred until another occasion.

FIRST DAY. AFTERNOON SESSION.

DR. BULKLEY read a paper entitled :

**"On the eczema marginatum of Hebra (*tinea trichophytina cruris*) as observed in America."**\*

In it he gave the details of twelve cases, which went to show that the disease presents much the same features in this country as abroad, but that it is as a rule milder in its course. He gave the credit to Bärensprung for having been the first to describe the disease carefully and accurately, under the term herpes inguinum, five years before Hebra published the first edition of his book, wherein it is called eczema marginatum. Dr. B. found a parasitic fungus in all of the cases in which he searched, ten, and all the patients were treated by the free external use of sulphurous acid. He desired to urge the value of this in the vegetable parasitic diseases, and attributed failures from it in the hands of others to its use in a weakened form, diluted either artificially or by a natural evaporation of the gas, or by a change of it back into sulphuric acid, which latter would prove useless as well as irritating to surfaces thus diseased.

DR. HEITZMANN remarked that the description given corresponded very closely with the disease as seen in Europe. The writer had criticised Hebra's treatment of eczema marginatum. Dr. H. had found Wilkinson's ointment effectual in six days ; he would, however, think well of sulphurous acid.

DR. DUHRING had seen the disease abroad, both in Hebra's wards and in France and England, but for some years past had seen no cases here until recently, of late he had observed cases resembling somewhat the milder ones described by Dr. Bulkley ; he thought that this disease, as well as many others, occurred in a milder form in Philadelphia than in New York or Boston. He would call it simply *tinea circinata cruris*, and thought that great care should be exercised in distinguishing between ordinary eczema and eczema marginatum.

DR. WHITE said that he had observed three different types of the affection under consideration : 1. *Tinea circinata* of the usual type ; 2. Eczema and *tinea circinata* occurring together, the eczema sometimes disguising the *tinea* ; these cases were somewhat rare ; 3. He had also sometimes met with simple chronic eczema resembling closely the eczema marginatum described by Hebra, occurring on the thighs, axillæ, etc. In these cases he was sometimes unable to assert positively whether eczema or eczema mar-

\* Published in Chicago Medical Journal & Examiner, November 1877.

ginatum were present without the aid of the microscope. Occasionally he was unable to find the parasite even when the various symptoms of *eczema marginatum* were present. Dr. White agreed with Dr. Heitzmann in regarding Wilkinson's ointment a valuable remedy, but had never obtained such speedy effects from it as Dr. Heitzmann named; he was much more apt to resort to it in hospital practice than to sulphurous acid.

DR. BULKLEY had seen the disease under Hebra and certainly never saw there any cases as mild as those here detailed. Dr. B. in the main agreed to the distinctions drawn by Dr. White, but he believed that when the well defined border made its appearance, that was the signal of the presence of the parasite; he recognized of course, that ordinary *eczema* of the same regions was of common occurrence. He held that the therapeutic argument was worth something in this affection, for in cases where the treatment for *eczema* failed, sulphurous acid would often be found to succeed; the latter would irritate instead of cure an *eczema*, as he had himself demonstrated clinically.

DR. VAN HARLINGEN read upon

### **"The pathology of *seborrhœa*,"**

and claimed that the scaly affection known as dandruff was not, in all instances, properly speaking, disease of the sebaceous glands, but rather one affecting the outer layers of the epidermis, and should be called *pityriasis simplex* rather than *seborrhœa* or *acne sebacea* as is commonly the case. The paper was based on an examination of the scales and debris scraped from the surface, and in the affection named, after extracting the oil by ether and drying the residue, the loss of weight was comparatively small, and under the microscope the scales represented those of the outer epidermal layer of the skin.

DR. FOX remarked upon a variety of *pityriasis* of the scalp where there was a general exfoliation of the epidermal layer, which, together with some sebum which was present, formed a mass adhering also to the roots of the hair in the form of sheaths; this under the microscope was composed almost wholly of epithelium. He also referred to a case which had been exhibited at the New York Dermatological Society, where the glans penis was completely enveloped by a membrane of whitish color, which could be separated from it, and which the microscope showed to be composed entirely of epithelial scales; it resembled much the covering sometimes formed by sebum over the glans; he thought the exfoliation of the epidermis in this case was analogous to that occurring on the scalp in *pityriasis*.

DR. WHITE said that this condition he had observed in one case to be the beginning of the formation of a horn upon the glans penis. He saw the case two years before the horn appeared; there was first a thickened mass, which could be dug out like putty from behind the corona; the horn which grew was large and long.

DR. VAN HARLINGEN, in answer to a question, said that he would regard pityriasis simplex as a separate affection of the scalp, distinct from seborrhœa; modern dermatology seemed to be settling down to but one pityriasis, that known as pityriasis rubra, he would claim at least one other affection meriting the title, the scaly one of the scalp now under consideration.

DR. FOX read a paper on

**"Molluscum contagiosum."**

It was based upon twenty-four cases which had fallen under his personal observation, five per cent. of these occurred on the male genitals; he believed the affection to be rare in private practice. He was not able to trace the contagious element with certainty in any proportion of the cases, but he had noticed what he thought a curious if not important coincidence, in the occurrence of ordinary warts on many of the patients or their immediate families. He expressed no opinion in regard to the contagiousness of warts, but thought the subject of sufficient interest to warrant further investigation as to the simultaneous appearance of these two skin lesions. He suggested that this disease should be called molluscum merely, and that the affection known as molluscum fibrosum should always be designated fibroma.

DR. FOX in answer to a question stated that he had seen the peculiar, round, shiny "molluscous elements" described by Virchow, in the microscopic examination of these tumors of molluscum.

DR. HEITZMANN had examined two cases microscopically, had found a fatty epithelial degeneration and the bodies which Virchow had held to be the carriers of contagion. He believed that there was some propriety in associating warts with molluscum contagiosum; some local irritation took place before the development of both. Discharging tubercles of this disease will have others around them, women with leucorrhœal discharges may have them upon the thighs, and blenorrhœa induces what are known as venereal warts; these latter may occur elsewhere than on the penis as the result of the irritation of this poison, he had seen them on the face in one case. He had also seen a large crop of ordinary warts begin on the hands of a gentleman as the result of laboratory work. Local irritation would not always produce papillomatous growths, but in certain cases there is the predisposition which renders the local agent active. He did not regard the molluscum contagiosum as contagious in the ordinary acceptance of the term.

DR. FOX, in answer to a question, said that about one-third of the cases occurred in families where more than one member was attacked, these were mostly children: he thought that in one-half the cases some other member of the family had, or had had the disease.

DR. DUHRING could not recall any cases where there seemed to be any connection between the disease and ordinary warts, or even

where the latter were present. On questioning it was found that no one present could remember any such cases.

DR. HYDE, referring to Dr. Heitzmann's remarks, said that the vegetations induced by fluids of a blenorhagia nature did not necessarily result in a single individual from even the most virulent of secretions. In certain cases an individual who has had several attacks of blenorhagia will find a most luxuriant development of vegetations first occurring after contact with secretions to which he is unaccustomed, and which are not nearly so acrid as those to which he had formerly been exposed. He thought some vaginal secretions especially productive of them, as they had seemed to cause them after gonorrhœa failed.

DR. WHITE spoke of the treatment of molluscum contagiosum. He had recently a prescribed means which he had found serviceable in ordinary warts; the latter he orders to be pared down, and then to have them moistened, and pulverized muriate of ammonia to be applied, as much as will adhere. In the case of molluscum he had had the remedy bored into the masses with a stick moistened and dipped into the same.

DR. HARDAWAY had treated ordinary warts successfully by means of electrolysis; transfixing the base with a needle attached to the negative pole, and placing the positive in the hand of the patient, he passed a current from two or three cells through it, for several successive days.

DR. FOX had not given much treatment to his cases of molluscum; where they were cut off for microscopic examination he had thrust a stick of nitrate of silver into the base. This he considered the best treatment.

DR. DUHRING had met with molluscum contagiosum several times in private practice, but it was a rare disease among the upper classes in Philadelphia; many of the gentlemen present had seen it only among the lower classes of society.

DR. WIGGLESWORTH had himself had molluscum contagiosum in half a dozen scattered tubercles, which began to appear about two weeks after squeezing the contents from the tubercles on a case of this disease; he was, however, skeptical in regard to the contagiousness of the disease in question.

DR. ATKINSON had observed it in his own child, there being three small mollusca.

DR. WHITE had seen several cases in the hospital, in patients who from their station in life should have been private patients.

DR. DUCKWORTH of London, had sent a paper on

### **"The treatment of severe bed-sores,"**

which was read by the Secretary. He advised the continuous use of a large poultice, covering the entire surface of the bed-sore; balsam of Peru may be added, if the condition of the sore requires it, or the cataplasma carbonis of the Pharmacopœia may be used. This



is the method followed with much success in the St. Bartholmew's Hospital.

DR. HYDE did not agree with the writer in regard to the value of poultices to bed-sores; he had seen very many of the latter during the late war, and had seen this method tried and abandoned. He mentioned the occasional irritating character of the oil of flaxseed; he had seen effects resembling hay asthma following the application of flaxseed poultices.

DR. WIGGLESWORTH's paper on

**"Faulty innervation as a factor in skin disease,"**

was read only by title, it not being yet ready, on account of his previous sickness.

The Association adjourned at 6 P. M.

SECOND DAY. MORNING SESSION.

WEDNESDAY, SEPTEMBER 5.

Business meeting at 9 A. M.

The report of the Treasurer and Auditing Committee was read and adopted. The total receipts had been \$100., the expenditures \$63.50, leaving a balance of \$36.50 in the treasury, together with \$40. still due from members.

The Nominating Committee reported the following list of officers for the ensuing year, who were subsequently elected:

*For President*, DR. JAMES C. WHITE of Boston.

*For Vice-Presidents*, DR. C. HEITZMANN and DR. L. DUNCAN BULKLEY, of New York.

*For Secretary*, DR. R. W. TAYLOR, of New York.

*For Treasurer*, DR. I. E. ATKINSON, of Baltimore.

The following gentlemen were elected members of the Association, on recommendation of the Council: DRs. WM. H. GEDDINGS, of Aitken, South Carolina; SILAS H. DURKEE, of Boston; FRANK P. FOSTER, of New York; and S. SHERWELL, of Brooklyn.

The following were elected honorary members: PROF. FERDINAND VON HEBRA, of Vienna; ERASMUS WILSON, F.R.C.S., of London; and DR. C. HARDY, of Paris.

The Committee on the President's Address reported the following for adoption:

"The American Dermatological Association agrees in each and every respect with the views laid down in the President's Address, and appoints the following standing committees:

*On Statistics*, consisting of DRs. WHITE for Boston, BULKLEY for New York, HYDE for Chicago, ATKINSON for Baltimore, VAN HARTLINGEN for Philadelphia, BRODIE for Detroit, HARDAWAY for St. Louis, and YANDELL for Louisville.

*On Nomenclature*, the President, *ex-officio*, as Chairman, with DRs. DUHRING, TAYLOR, WIGGLESWORTH and HEITZMANN.

The Bibliography of articles written by members of the Association and others, as presented by the President, was recommended to be published with the President's Address, in the proceedings of the Association.\*

The Council recommended the following changes in the By-Laws, which were adopted: SECTION I, to be altered so as to read "The annual dues shall be five dollars, to be paid at the beginning of each year. Any member who is in arrears for more than one year shall be dropped from the roll by vote of the Association." SECTION III to be amended so as to read "The titles of all papers to be read at any annual session shall be forwarded to the Secretary not less than *two* months before the first day of the session, and the titles announced in the notices of the meeting."

The Council also announced, in accordance with Article VIII of the Constitution, (which provides that notice of a proposed amendment shall be given in writing at the annual meeting immediately preceeding the one in which it is to be voted upon,) that it would, at the next annual meeting, propose to add the following clause to Article IV, namely: "The Association shall have the power to declare forfeiture of membership in the case of any member who ceases to exhibit an active interest in the science of Dermatology."

The Association, on the recommendation of the Council, decided that it was not expedient to publish a separate volume of transactions during the present year; the proceedings were ordered to appear in the ARCHIVES OF DERMATOLOGY, and the Council directed to return to the authors papers which have been read and accepted, that they may publish them where desired.

DR. HYDE announced a brief paper describing a "rare form of multiple, congenital and monolateral pigmentary nævus," and received permission to present it.

DR. CAMPBELL read a paper on

### **"A case of true prurigo (of Hebra)."**

The boy, aged 11, had exhibited the eruption since two years of age, and presented all the features recognized to be characteristic of the disease.

DR. DUHRING had seen the case and was impressed with the correctness of the diagnosis. It was only the second case which he had seen in this country, the other being seen in Boston, a patient of Dr. Wigglesworth, a boy of 14, whose history had been reported. He had however, seen a third case presenting many of the symptoms and which for a while he thought to be one of true prurigo, but subsequently he had doubted if it were; it was in a girl aged 20, who was in the Hospital a number of years, and who died while he was absent, and no necropsy was obtained.

DR. HYDE had seen one case which he considered prurigo.

\* Published in full in this issue of Archives of Dermatology, page 14.

DR. FOX saw the patient under consideration and had no hesitancy in pronouncing it to be one of true prurigo. He had seen one other case of this disease, in a boy 5 or 6 years old which he had exhibited before the New York Dermatological Society. It had first developed at two years of age and had remained present since. He had also exhibited another patient before the society in whom a chronic eczema so resembled prurigo that the diagnosis between them was difficult.

DR. WHITE had never seen a case of true prurigo in this country and believed the disease to be very rare outside of Germany. He had seen a number of cases in which the eruption resembled prurigo very much, but he did not regard them as such; he believed that the diagnosis could not be made on the appearance of the eruption at any one time, the case should be kept under observation as its characters may change.

DR. WIGGLESWORTH regretted that Dr. White had not seen the case which he had reported in the *American Journal of Syphilography and Dermatology*, January 1873, and already alluded to by Dr. Duhring. He had seen one other case since that time, occurring on a farmer of about 40 years of age, in whom the formation of papules, the thickening of the skin, the buboes in the groins, the locality of the parts affected, the peculiar appearance to the eye, and to the fingers after rubbing them on the lower limbs, the discoloration, etc., were all symptomatic of prurigo. The only opposing evidence was the statement of the patient that the disease did not appear first in infancy; it had begun first when he was from 12 to 15 years of age, and at the time of observation the man was 40 years old. The case was lost sight of and the further history was not known.

DR. BULKLEY had seen Dr. Campbell's case and examined it several times and agreed wholly as to the diagnosis. He had also seen the one exhibited by Dr. Fox at the New York Dermatological Society, and also another case, which Dr. Taylor had observed for a long time, and could describe more perfectly than he, making in all three undoubted cases of prurigo in this country; he was familiar with the disease as observed in Hebra's wards. He had also watched a case for a long time, which he considered at first to be prurigo, but as there was some doubt in his mind he did not wish it to go on record as an authentic case.

DR. TAYLOR spoke of the case alluded to by Dr. Bulkley. The patient was a Jew, born in Austria, 40 years old. The disease had begun in early life, was under observation fifteen to sixteen months and grew progressively worse during that time.

DR. HEITZMANN was familiar with the disease abroad, but had not yet seen a case in this country.

DR. YANDELL had seen one case which at the time he considered prurigo, but now doubts the diagnosis.

DR. BULKLEY remarked that the total of the experience of the gentlemen present footed up but six cases of undoubted prurigo in

this country ; there were three doubtful cases mentioned, and several of the gentlemen had never seen a case in this country.

DR. HYDE read a paper upon

**“The immunity of certain mothers of children affected with hereditary syphilis.”\***

He reviewed the subject of paternal and maternal infection in syphilis, holding that in certain instances, notably those in which the father alone had constitutional disease, it was possible for the mother to bear an hereditarily syphilitic infant and yet escape infection. He argued also against the so-called “syphilis by conception,” believing that, as the blood of the father is contagious, direct infection may take place by means of an abrasion, without the necessity of supposing an infection which may be termed trans-placental. He believed, moreover, that it was more than probable that Colles' law would be found true in regard to the father as well, namely, that although non-syphilitic, he is never infected from his own syphilitic infant.

DR. HARDAWAY thought that the law of Colles admitted, still further application, namely, that a child born of a syphilitic mother, even though it show no signs of syphilis is incapable of acquiring the syphilis after birth from the mother.

DR. TAYLOR believed with Kassowitz that the child may be infected by the father alone while the mother remains free, as opposed to the view of Cullerier who denied paternal infection.

DR. ATKINSON maintained that the syphilitic poison was capable of transmission by any of the elements of the body, blood, sperm, lymph, etc., and was even transmitted by means of protoplasm, and that no membrane could stay its progress in the inherited any more than in the acquired disease, as is evidenced by the infection of the child by the mother, through the membranes of the placenta.

DR. HEITZMANN read a paper entitled

**“On the relation of impetigo herpetiformis to pemphigus.”†**

DR. FOX thought that the elementary lesions were often too much studied in skin diseases, whereas they are only one element in the case. Thus, the term pemphigus is applied to eruptions to which it is inappropriate, simply because of the bullous character of the lesion. The term pemphigus should be restricted to the chronic, fatal form, also to acute forms which are severe and fatal, whereas there are other eruptions presenting bullæ, which are similar anatomically, but the disease is of a very different nature. To these he would apply the provisional name hydroa. The cause in the one case is temporary, in the other permanent.

DR. DUHRING had never seen a case similar to the one of Dr.

\*This will appear in full in the next issue of the Archives of Dermatology.—ED.

†Published in this issue of the Archives of Dermatology, page 37.

Heitzmann. He asked if he regarded the disease in the case mentioned as a variety of malignant pemphigus? The lesions of pemphigus varied, there being sometimes pustules rather than bullæ.

Dr. HEITZMANN was doubtful as to the true relations of the diseases. He was inclined to retain the name impetigo herpetiformis, as at first there were only small pustules.

Dr. BULKLEY asked in regard to the use of arsenic in this case, and alluded to its very great efficacy in pemphigus.

Dr. HEITZMANN said it had been given in moderate quantity.

Dr. BULKLEY said that much in the case reminded him of one of gangrenous pemphigus, which he had observed\* where arsenic twice appeared to save life. As in the case described by Dr. Heitzmann, early in the disease the eruption had been mistaken and treated for one of syphilis by those in attendance, there being lesions within the mouth also in this case, which partly led to the confusion. The pulpy condition of the base of the bullæ corresponded much to that described in Dr. Heitzmann's case. He would hardly think that arsenic had received a fair trial in the case reported by Dr. Heitzmann. It is necessary in such cases to increase the dose rapidly, and to take the remedy every few hours, even until some toxic or physiological effects are produced. In the instance referred to, the improvement after a few good-sized doses of arsenic was marvellous.

The Association adjourned at 1.30 P. M.

## SECOND DAY. AFTERNOON SESSION.

Dr. HARDAWAY read a paper entitled

**"The lymphatic theory of syphilitic infection, with a new view of the relation between the chancre and chancroid, and suggestions for the radical cure of syphilis."**†

He entered fully into the literature of experimental and clinical evidence of the absorption of the syphilitic virus through the lymphatic system, demonstrating the same very conclusively. He held that both the chancre and chancroid were the results of inoculation with syphilitic virus, but that the latter, the chancroid, or soft suppurating sore, is due to the greater virulence of the contagious agent, or more especially, perhaps, to a pyogenic predisposition of the person infected, and that the change of the white blood cells into pus cells rendered them incapable of carrying the true syphilitic contagion. The proposal for the radical cure of syphilis was the very early excision of the enlarged and indurated glands in the groin, before the poison had passed them and affected the next

\*American Journal of Medical Sciences, October, 1877.

†New York Medical Journal, December, 1877, p. 580.

set of glands within the pelvis. This, of course, could be done only in cases which had been watched from the beginning.

DR. ATKINSON was much in accord with the writer. The idea that the induration of the chancre was essential to infection was being abandoned, because of the fact that induration is such an uncertain element to determine in every case, and therefore the practical results from such a sign were uncertain. Aside from any peculiar contagion of the chancre or chancreoid, all pus is contagious to a certain degree. Now, by repeated inoculation and development, the pus may become so virulent that it is incapable of being absorbed, on account of the local irritation which it excites, and the result of the contagion remains local. May not this be the origin of syphilis, namely, a pus which has undergone some change in development; while, when this change proceeds still further, the more highly poisonous pus is arrested at its point of entry, and results in the chancreoid. This arrest is a salutary measure, otherwise the results of the more severe purulent infection might be more destructive of life than syphilis itself. In dissecting wounds a smaller amount of less virulent poison is absorbed, and infects the system; when the virus is very irritating it is not absorbed, but produces a local sore only.

DR. HYDE thought that conclusive proof existed that syphilitic, as also other infection, took place through the agency of the lymphatic system. He recalled the experiment of Maurice Reynaud, who produced horse pox by inoculation, and when the vesicles were fully developed, he laid bare the lymphatic vessel passing from the site of the lesion, and injected the lymph from this into the jugular vein of another horse, with the result of having subsequent development of the constitutional disease.

DR. HEITZMANN criticised some of the experiments and reports quoted in Dr. Hardaway's paper; it is difficult, he thought, to determine anything definitely from data thus disjointed; some of the observers were reliable, others were not. He believed that ultimately the microscopic study of living matter will determine the true relations of such poisons as syphilis. In healthy persons the white corpuscles are more coarse and granular than in those with health broken down, as tuberculous patients. Pus corpuscles also present different characters under different circumstances. He believed that there was evidence enough that the white corpuscles convey the poison, and thought the suggestion made of extirpating the infected lymphatic glands a natural one, but he thought it an unreliable method, probably, because of the difficulty of determining in advance exactly when it will be successful.

DR. TAYLOR read a paper

### **"On the xeroderma of Hebra."**

In it he detailed the histories of seven cases of this rare affection, five of them existing in two families. The disease began in

very early life, and had progressed continuously. Photographs of five of the cases were shown.

DR. HEITZMANN had seen previously four of these cases, and had made the same diagnosis. He had also seen in Vienna the two cases described by Kaposi, and he had had another case under treatment in this country, making eight in all. The case referred to as under treatment is in a man aged 40 years, who had had the disease thirty or thirty-one years. There were freckle-like patches on the face and hands, and an ulcerative lesion on the left cheek, which he first regarded as rodent ulcer. He had removed this with the sharp spoon four times. One month ago he removed in the same way four new nodules; they seem to recur about every six months. The wounds heal very kindly after the operation. Microscopic examination of the masses removed showed them to be epithelial cancer, as the masses were called by Kaposi in his case. There was certainly an epithelial new formation, but there were none of the epithelial nests characteristic of this disease.

DR. BULKLEY remarked that three or four of these cases had been exhibited by Dr. Weisse before the New York Dermatological Society several years ago. The name then given to the cases was multiple pigmentary nævi, with lupoid degeneration, which seemed to him to express the clinical features of the disease far better than the term xeroderma, which in this country, as also elsewhere, had been applied to quite a different affection.

DR. WHITE called attention to the affinity of this disease to other pigmentary affections, especially to the morphœa, as described by Wilson. In this the erythema often persists for a long time, and is then followed by atrophy; the new formations are rather accidental features in the disease, which may take place in other affections as well, where there is papillary hypertrophy or pigmentary deposit.

DR. HEITZMANN thought Hebra's designation of xeroderma a correct one, as he considers the atrophic element important.

DR. DUHRING had never met with anything closely resembling these cases, but he thought the resemblance to morphœa, the old keloid of Addison, traceable in some features. In the case of a young lady an abundant and marked feature of the disease consisted of lesions resembling telangiectatic spots, covering a definite area, lasting for a while and changing into deep pigmentation, which latter again underwent resolution. He thought it difficult to determine certainly if morphœa were an hypertrophic or atrophic affection, but inclines toward the latter.

DR. YANDELL read a paper entitled

### "The etiology of cutaneous diseases."

In it he claimed that, aside from parasitic diseases, syphilis, etc., the large majority of acute diseases of the skin, as eczema, urticaria, erythema, etc., were caused by malaria, while the chronic

affections were due to scrofula. He instanced the universal prevalence of the malarial poisoning, and that the negro race, who are usually so free from its effects, are likewise remarkably free from the acute eruptions on the skin.

DR. BULKLEY asked Dr. Yandell if he had treated cases of eczema by quinine alone, without any other external or internal remedy, and cured them; especially had he treated infantile eczema thus?

DR. YANDELL said that he had; that he often remarked the periodicity in the itching of eczema, and found it to be relieved by quinine and other antiperiodics, without other treatment.

DR. ATKINSON asked why it was that negroes, who are more prone to scrofula than individuals of any other race, did not have the skin diseases which he attributed to this cause. They should, on his supposition, suffer more from them, whereas they are unusually free from all cutaneous maladies?

DR. WHITE asked if, in the opinion of the writer, these acute skin diseases could occur without a malarial origin?

DR. YANDELL replied that any agent causing poverty of blood, as alcohol poisoning, starvation, etc., could have the same effect.

DR. WHITE thought that Dr. Yandell undoubtedly saw skin diseases in patients suffering from malaria, but doubted any connection between the two. Intermittent fever is unknown in Boston, whereas these acute affections of the skin are common, and he believed that these eruptions will not be found by statistics to be more abundant in malarious regions than in those where this influence does not exist. He granted that skin diseases could be *influenced* by malaria in periodicity, etc., but thought that they could not be thus caused. He would like statistics on the subject.

DR. BULKLEY was certain that the malarious element was of little or no account in this class of affections in New York City. He would like very much to have the matter referred to the Committee on Statistics for investigation and the collection of data.

DR. HEITZMANN remarked that the same subject of the influence of malaria in the production of skin diseases had been brought up by Dr. Poor, of Pesth, in Hungary, more than ten years ago, and had been entirely disproved in Hebra's clinic. Scrofula, which is very common there, was also thought to be a prolific agent in causing skin affections, but he believed that this had also been disproved long ago.

Adjourned at 7 P. M.

### THIRD DAY. MORNING SESSION.

THURSDAY, SEPTEMBER 6.

It was voted that the Council be directed to have the President's address, together with the bibliography attached, reprinted with the proceedings of the Association.

The Association having lost one of its members by death, Dr. H. C. Hand, of St. Paul, Minnesota, Dr. Fox was appointed a com-



mittee to draw up appropriate resolutions. The following resolution was offered and adopted, and ordered to be inscribed on the minutes, and a copy transmitted to the family of the deceased :

*"Resolved :* That in the death of Dr. H. C. Hand the American Dermatological Association has lost a member whose character and attainments were such as to command the admiration and win the love of all who knew him."

DR. DUHRING read a paper entitled

**"Case of an undescribed form of fragilitas crinium."**

It had reference to a gentleman, the skin of whose bearded face presented erythematous and scaly patches, which appeared to be due to a splitting of the hair within the follicles. The hairs could be extracted without pain, and were largely found to be thus affected. When the beard grew long, the splitting caused great annoyance. If, however, he shaved daily, but little trouble was experienced. The hairs were shown beneath the microscope ; also drawings of the same.

DR. HARDAWAY had had this same patient under observation for some time, but could add very little to what Dr. Duhring had said. He had seen him lately, and the patient, who is an intelligent physician, thinks he is better. He had contracted syphilis from a wound on the finger, and was now suffering from the constitutional symptoms.

DR. WHITE asked if the splitting begins *within* the follicle ; and if the hairs should grow to a half inch in length, would the splitting be *within* the follicle ?

DR. DUHRING said that at the end of ten days growth of hair the splitting was very great. It appeared to take place directly at the surface, or within the follicle. He regarded the process essentially as an atrophy, although certain portions of the hairs appeared still as if hypertrophied.

DR. WHITE could not see how there could be both atrophy and hypertrophy in this case ; after the hair is once formed, he could not understand how it could increase outside of the follicle. He thought the increase in size only apparent, caused by the separation of the composite parts of the shaft, as in the case of the disease described by Beigel, where the bulging takes place in the shaft, and the masses appear as if hypertrophy had taken place. He had seen cases of this disease ; the hair broke off, and then the splitting would continue down to the skin ; he thought that possibly the splitting might have begun outside the follicle, and have continued down into it in Dr. Duhring's case. He suggested epilation as a therapeutic measure in this case, to be repeated and continued for some time, to cause, as it were, the hairs to begin anew. He inquired if the erythematous state of the skin were a primary or a secondary affair ?

DR. DUHRING could not answer this. He had thought that the distension of the hair within the follicle had caused the hyperæmia.

DR. BULKLEY read a paper upon

**"Two cases of very late hereditary syphilis."**

They were presented rather to introduce a discussion of the subject of the very late manifestations of skin lesions in the subjects of inherited syphilis. The cases were in females of twenty-three and twenty-four years respectively. In the former a gummy ulcerating syphiloderm had first appeared within a year. In the other case there had been a recurring or almost continual, small tubercular eruption since seven years of age.

DR. TAYLOR had seen several cases of late hereditary syphilis, but is skeptical of skin lesions appearing after 20 years of age; he thought that later lesions would be more apt to be bony, and that the skin enjoys an immunity after the age of 20 years.

DR. ATKINSON referred to his case published in the ARCHIVES OF DERMATOLOGY for January, 1877, of syphilis inherited through two generations. In this instance the eruption had re-appeared since the case was published, that is, at about the 20th year.

DR. BULKLEY said that there could be no question in regard to the syphilitic character of the eruption in the cases reported: in the first case a large share of the indications of hereditary syphilis were present, the teeth were most typically notched and deformed, the history of the mother in regard to syphilitic eruptions, abortions, etc., was perfect; the girl had certainly not acquired the disease, and the gummy masses were yielding rapidly to anti-syphilitic treatment. He differed entirely from Dr. Taylor in regard to the immunity of the skin late in hereditary syphilis; these cases were rare, but others had been observed as well.

DR. WHITE, speaking in regard to the value of the notched teeth, said that he knew of a case of a boy who presented the central incisors notched from side to side and the lateral incisors wanting, where the suspicion of syphilis was excluded with the most absolute certainty; all the other teeth were normal. The deformity followed a sudden and severe attack of inflammation of the glands of the neck.

DR. BULKLEY recognized and had been accustomed to point out deformities of the teeth which often resembled those occurring in hereditary syphilis, and he believed that the practiced eye could determine with very great certainty those due to the action of the syphilitic poison and those dependent upon scrofula, acute sickness, etc.

DR. VAN HARLINGEN exhibited some leaden tubes, such as are used to hold liquid paints, which he had employed to contain ointments; he had gotten the suggestion from some French source. They were particularly serviceable when traveling, or when ointments were to be kept a long time; he had found diachylon ointment to harden from exposure to the air when dispensed in the ordinary manner. The tubes could be obtained of all sizes, from Remington, corner 18th and Walnut Streets, Philadelphia.

DR. BULKLEY suggested that he had found a layer of water placed over the surface of diachylon ointment preserves it perfectly.

DR. WHITE at first had difficulty with diachylon ointment, but now he has no trouble in keeping it any time ; it is always soft and of the consistency of butter. He is careful always to have only the best olive oil used, and a small portion of oil of lavender is added.

DR. HEITZMANN said that there was no difficulty in Vienna with the diachylon ointment. The main point to be observed in making it, is always to boil it over a water-bath. When there is no counter-indication he adds balsam of peru (3j ad 5j); it keeps better and the fragrance is pleasant.

DR. DUHRING\* adds a few grains of benzoin to the ounce.

DR. ROBINSON's paper on

**"The pathological histology of psoriasis,"**

was read only by title, owing to the absence of the writer.

DR. WIGGLESWORTH's paper on the

**"Auto-inoculation of vegetable parasites, of the skin, and the clinical testimony for their identity or non-identity,"\***

was read only by title, owing to previous sickness, on his part.

DR. TAYLOR's paper on

**"Affections of the testicle in hereditary syphilis."**

was presented by title only.

It was moved and carried, that the Association direct to be printed at the beginning of its proceedings, the following :

"In accepting papers read before it, the AMERICAN DERMATOLOGICAL ASSOCIATION by no means endorses all or any of the opinions expressed in them."

The papers read before the Association were then accepted, with the exception of that of Dr. Brooks, which was referred back to the author, with thanks, the reasons for its non-acceptance being that it did not treat of subjects connected with the objects of the Association.

The papers of Dr. Wigglesworth, which were read by title, were accepted, that of Dr. Robinson, read by title, and the second paper of Dr. Taylor, were referred to the council for action.

A vote of thanks to the proprietors of the Cataract House, for courtesies extended to the Association, was unanimously passed.

The Association adjourned, to meet next at Saratoga Springs on the last Tuesday in August, 1878.

\* Published in this issue of the Archives of Dermatology, page 28.

## Digest of Literature.

### I.

#### DISEASES OF THE SKIN.

##### ANATOMY, PHYSIOLOGY AND PATHOLOGY.

A. R. ROBINSON, M. D.

**Structure and growth of epithelium of the cornea and skin.** DR. CHARPY thinks epithelium always grows by transverse segmentation of the deep cells. The subject, though apparently simple, is really one of the most difficult in histology, and we do not think we possess any positive knowledge of the process. *Lyon Méd.*, p. 9, May 6, 1877.

**Experiments in colored skin grafting.** DR. MEYER used portions of skin from the negro for skin grafting on white persons, and found that the grafted pieces retained their color, and always reproduced their kind. *Chicago Med. Four. and Exam.*, p. 320, April, 1877.

**Contribution to the knowledge of the modified sweat glands of the edges of the lids.** As is well known, the sweat glands of the eyelids differ from those in other regions of the body in that they have no coiled deep end. It is even doubtful if they ever open on the free surface of the lids.

DR. SATTLER has never found them opening in this location. Neither, according to this author, do they all end in a sebaceous gland, but frequently terminate in a hair follicle. He also finds that they are possessed of a muscular layer which runs parallel with the long axis of the duct, and ceases to exist when the duct enters the follicle. *Archiv. für Mikroskop. Anat.*, XIII., 4.

**The nerve endings in the epidermis.** The snout of the common pig was made use of by VON MOJSISOVICS to study the mode of termination of nerves in the epidermis. The author found that the nerve fibres pass from the cutis into the epidermis, and thence to the surface, dividing dicotomously as they proceed upwards. The fibres run exclusively between the epithelial cells, and do not anastomose with each other. He never found the star-formed endings described by Langerhans. *Central-Blatt für die Med. Wissenschaften*, April 28, 1877.

**Local action of dilute acids on the living tissues.** The deductions of DUMONLIN on this subject are as follows: (1) The tolerance of living tissues for the acids is very small. (2) It is generic, and equal for all. (3) It is in inverse ratio to the concentration, multiplied by the volume of the injected fluid. (4) The effect is proportional to the absolute quantity of an acid, and not to the degree of its dilution. (5) The tolerance appears to be directly proportionate to the volume of the animal. (6) In imbibition by the tissues the acids coagulate the blood and the blood vessels, and arrest the circulation in all the part impregnated. (7) That imbibition produces hemostasis, accompanied at first by hyperalgia, but soon by anæsthesia. *Acad. Roy. de Med. de Belg. Gaz. Hebd., p.493, Aug. 3, 1877.*

**The effects of the application of metals to the skin in cases of anæsthesia.** DUMONT PALIER found that in a certain form of hysteria, if pieces of gold, copper or zinc were applied to the portions of skin in which the sensibility was changed, the patient complained immediately of a sense of tingling, a sensation of heat, and soon afterwards there was a return of sensibility and elevation of temperature. Special sensibility was effected in the same manner. The same metals did not always produce the same effect, some patients having an idiosyncrasy for one of the three metals, while the others might not produce any effect. Whilst the sensibility, temperature and muscular force on the one side returned, it was lost upon the corresponding part of the other side. *Le Prog. Méd., p. 309, April 21, 1877.*

**Cutaneous respiration.** FUBIN and RONCHI experimented on the human subject, for the purpose of finding out the amount of carbonic acid given out by the body when under different conditions. From these experiments it was shown that more carbonic acid was given out in the dark than when exposed to a bright light, the proportion being as 112 : 100. The amount increases also with the increase of the temperature. The amount of acid was also greater when the person used a purely vegetable diet than when he used a meat diet. *Central-Blatt, f. d. Med. Wissensch., March 3, 1877.*

**The effects of varnishing the skin.** DR. SENATOR denies that the inferences which have been drawn from the effects of the varnishing of animals are applicable to human pathology, and asserts that the human skin can frequently be covered with an impermeable material for several days without injury to the person thus covered. While coating of rabbits with an impermeable material causes within a short period lowering of the temperature, albuminuria, and death, he has never observed any of these results in the human subject, even when the person has been coated an entire week with an impermeable material. *Virchow's Archiv., June, 1877. British Med. Journ. p. 427, Sep. 22, 1877.*

**The innervation of the sudoriparous glands.** SUCHINGER experimented on cats, and found that excitation of the sciatic nerve produced sweating of the corresponding side. If the sciatic nerve was divided, then it was impossible to produce sweating of the corresponding side. Atropin, even in small doses, always paralyses the secretion. These points show, he thinks, that sweating is only possible by a direct nervous influence, and that the sweat is a true secretion, and not an excretion of matter already formed. According to these experiments the sweat fibres of the sciatic nerve come from the abdominal plexus of the sympathetic. The sweat fibres of the sympathetic come from the spinal cord, especially from the anterior roots of the lumbar portion and inferior part of the thoracic, but not from the sacral portion. At this part of the cord are located the nerve centres, where the sweat fibres have their greatest activity. These centres of sweat react under the same irritation as other centres. *Corresp.-Blatt f. Schweiz. Aerzte, No. 22, p. 648, 1876. Rev. des Sciences Méd. p. 439, Oct. 15, 1877.*

**Anatomy of the initial induration of syphilis.** In this article AUSPITZ and UNNA endeavor to give the histology of the initial lesion of syphilis, and the cause of the induration so peculiar to the hard chancre. According to these observers as soon as the first trace of induration can be recognized with the finger, the most superficial network of blood vessels in the indurated spot is changed into an infiltration area, combined with peculiar changes of the arteries, veins, capillaries, blood vessels, lymphatics and connective tissue of the same region. If this sclerosis passes into a hard tubercle, then the deeper network of blood vessels also becomes changed into an infiltration area, which is connected with the superficial induration by a peculiar sclerosis of the intervening connective tissue, by which is formed the indurated chancre. The amount, therefore, of the induration will depend upon the amount of tissue lying between the superficial and the deep network of blood vessels. If the real cutis is very thin, then there will be a parchment-like induration. If the subcutaneous tissue is well developed, the amount of indurated tissue will be correspondingly large.

In the early stage of the induration hypertrophic and hyperplastic processes occur in the small blood vessels, and especially an active nutrition change in the adventitia. A narrowing of the calibre of the blood vessels was not noticed. The beginning of the process in the true skin is characterized by cell growth around the blood vessels, sclerosis of the surrounding connective tissue, swelling and outgrowth of the connective tissue cells, and proliferation of their nuclei between the bundles. The cause of the induration is the sclerosis of the connective tissue, which occurs within a limited area of the changed blood vessels. They thus differ from Biesiadcki, who thought the induration arose from dryness of the connective tissue from interference with the circulation in the part.

There is at first hypertrophy of the epidermis, especially towards the centre of the indurated spot, and afterwards a separation of the cells from each other by granulation cells, forming compartments in the epidermis.

The form of the sclerosis depends upon the pre-existing distribution of the blood vessels in the skin, its size upon the extent of the hypertrophy of the fibrillary connective tissue, in which the sclerotic vessels lie, and the density and hardness of the papules are proportionate to the strength of the hypertrophy of all the elements of the skin, or to the pressure under which the hypertrophic epidermis and hypertrophic connective tissue reciprocally split up or penetrate each other. *Viertelj. f. Derm. u. Syph. Heft I. und II, Jahrg. IV, 1877, p. 162.*

**Giant cells in syphilis.** BAUMGARTEN and BROWICZ have both found giant cells in syphilitic new growths, especially in gum-mous tumors of internal organs. Giant cells have been found in so many morbid conditions of the system, and even in healthy persons, that they cannot any longer be considered diagnostic of tubercle, unless they have other special characters, and are surrounded by a specially arranged and formed tissue. *Centralbl. f. die Med. Wissensch., No. 45, 1876, and Nos. 19 and 22, 1877; Vierteljahresschr. f. Derm. u. Syph., 1877, Heft III., p. 399.*

**Contributions to the pathological anatomy of leprosy, with lithographic drawings.** DR. KARL DEHIO agrees with Virchow as to the history of the newly formed elements. The first development of the disease takes place in a layer which is separated from the rete mucosum by a strip of healthy tissue. It sends processes upwards to the epidermis, and downwards to the fat globules. In the course of its development it is found in the lymphatic spaces of the cutis, and around the fine blood vessels. It is found specially developed around the sweat glands and hair follicles. The sebaceous glands resist longer. In the macular form the fat globules are not affected, but in the tubercular form they are much infiltrated. The veins showed degenerations resembling considerably those found in syphilitic arteries. *Dorpater Med. Zeitschr. Band VI., 1877, p. 232. Lond. Med. Record, p. 290, July 15, 1877.*

**Contribution to the study of ichthyosis and the epithelial growths in the same; together with observations on the exchange of hairs.** DR. ESOFF examined microscopically portions of skin from the dead body of an ichthyotic patient, and gives minutely the abnormal appearances presented. [That these changes here described are common to all cases of ichthyosis, we cannot believe. The observations of Hilton Fagge and others on this disease, already show that the morbid conditions present in one case, may be entirely absent in another. With a fuller knowledge of the subject, we will probably

be able to associate certain constant changes with a given variety of disease.—*Rep.*]

Dr. Esoff considers the nature of the disease to consist in an increased growth of epithelial cells with at the same time an increased disposition of those cells to pass into the horny condition. *Virch. Arch. Bd.*, 69., p. 417,

**The minute anatomy of scarlatina.** DR. KLEIN examined, with special reference to the condition of the kidneys, spleen, liver and lymphatic glands, the bodies of twenty-three persons, mostly children, who died of scarlatina. As regards the kidneys, during the first week of the disease, the nuclei of the malpighian bodies were found increased in size. The intima of the minute arteries had undergone hyaline degeneration, they were swollen into cylindrical hyaline structures, with narrowing of their lumen. At the same time larger or smaller portions of the glomeruli became impermeable—hyaline at first, fibroid afterwards, while Bowman's capsule also appeared hyaline. There was also multiplication of nuclei of the muscular coat of the minute arteries; parenchymatous nephritis with swelling and multiplication of the nuclei of the epithelium and a granular appearance of the tubules and malpighian bodies.

After the second week there was infiltration around the tubules and parenchymatous nephritis. He considers interstitial nephritis a constant lesion. If this is so we would like an explanation of the cause of the usually favorable termination of a nephritis depending upon the poison of scarlatina.

As regards the lymphatic glands of the neck, he observes that the uninuclear cells of the central part were greatly diminished in number and their places occupied by large multinuclear cells with intermediate forms, while the peripheral parts of the glands were occupied by lymph cells.

In the liver was observed (1) granular, opaque swelling, or even fatty degeneration of the hepatic cells; (2) a change in the arteries similar to that in the renal vessel; (3) great thickening of the intertubular connective tissue of Glisson's capsule.

The spleen presented (1) enlargement of the malpighian bodies; (2) hyaline degeneration of the intima of the arteries; (3) multiplication of the nuclei of the muscular coat of these vessels; (4) adenoid growth around the arteries; (5) infiltration of the lymphatic follicles with large hydropic cells. *Med. Times and Gazette.* May 5, 1877.

**A condition of the skin microscopically in staining from the internal use of nitrate of silver. (Argyria.)** In a case of argyria, examined by DR. NEUMANN, metallic silver was found deposited in all the tissues of the skin except the gland cells, and the cells of the rete malpighii. The largest amount was found close below the rete malpighii. Sometimes the sweat glands had the largest amount. The interior of the



gland, however, was always free. The hair and hair root were also free. The nature of the process remains still a disputed question. *K. K. Gesellsch. der Aerzte in Wien, March 9, 1877.*

**Histology of epithelioma.** DR. THINN finds, that in the centre of the enlarged rete mucosum, and in the concentric layers of the laminated capsules, the cells are much larger than normal. They flatten out and acquire a dried, horny aspect. Others we have and have the appearance of a somewhat spherical, homogeneous, vitreous mass. He finds that a laminated capsule frequently has its points of departure in an altered duct of one of the sweat glands. He finds that the epithelial growth takes place from the rete mucosum, glands, and hair follicles. He has not once seen (and this is of importance) an epithelial cell in such a condition as would indicate that it was in the process of dividing into two, or giving birth to an endogenous progeny, and maintains that an epithelial cell in a cancerous tissue never begets another cell or cells. He describes the different changes which a nucleus may undergo, and from the appearances sometimes presented, the idea of proliferation originated. The nucleus of the epithelial cell undergoes one of two transformations. It withers and falls into pieces, or, in a swollen, vitreous cell, it undergoes similar characteristic changes to those that take place in the cell. In this disease, he says there is an abnormal growth of epithelium, and a morbid condition of the fibrillary tissue of the cutis. Which of these two factors is the earlier in point of time, or the most important in point of development, he is not prepared to say. When the blood-vessels of the papillæ are choked by the growing epithelium, the destruction of the fibrillary tissue is probably hastened; but in the cutis, long before any pressure can be exercised on the blood-vessels or tissue, the bundles have begun to undergo absorption. An extravasation of lymph-corpuscles into the spaces of the tissue occurs, and from these he thinks the new epithelial cells are formed. He believes that in health epithelium is regenerated from lymph-corpuscles coming into contact with the epithelial cells, and that the area to which the epithelium can act on those cells is limited. In cancer, on the other hand, the potential epithelial area extends along the lymph spaces of the adjacent tissue, and the lymph cells present in it undergo changes which occur in health, only when they are in direct contact with normal epithelial structures. *Med. Chirurg. Transactions, Vol. LIX.*

**Microscopic appearance of some diseased skin.** DR. THINN gives the microscopic appearances of the skin from a rare variety of skin disease. No diagnosis was made, as the disease did not correspond with any of the already named skin diseases. The morbid appearances consisted in the presence in the corium of rounded, oval, or polygonal cells of different sizes with a spherical nucleus. The cellular infiltration began in the superficial

stratum of the corium, immediately around the blood-vessels. Thence it spread downwards along the blood-vessels, the hair follicles, sebaceous glands, and arrector pili muscles. Wherever the cells were formed, the gelatinous corium tissue was broken up or disintegrating. The epidermis was normal. [The microscopic appearances corresponded therefore closely with those of lupus as given by Virchow. The case is interesting, and if other similar cases are as thoroughly studied, we will soon be able to give the disease its proper place and designation.—*Rep.*] *Clin. Soc. London Med. Times & Gaz.*, p. 655, June 16, 1877.

**On the location of the pock in the epidermis, and on the first stage of the variolous process.** UNNA examined portions of skin from the sole of the foot affected with small-pox eruption, in different stages of development. He describes the first stage as that of hypertrophy or inflammatory swelling. The younger layers of the epidermis and the stratum lucidum are swollen and loosened. The enlargement of the rete and of the stratum lucidum causes an elevation of the epidermis. The further enlargement of the pustule arises entirely from the stratum lucidum.

The second stage of the eruption can be called the formation of the pox cavity, and here his description does not differ essentially from some previous writers. *Archiv. f. Klin. Med.*, Vol. LXIX, 304. *Viertelj. f. Derm. u. Syph.*, 1877, p. 224.

**Note on the anatomy and pathology of the skin.** DR. J. COLLINS WARREN describes fat canals passing from the adipose tissue through the cutis vera to the hair follicles, especially those of fine hairs. These canals, he says, are cylindrical in form, and are not lymphatic spaces. A sweat gland frequently lies in the canal. We have often seen such prolongations of the adipose tissue, but did not regard them as true canals. *Boston Med. & Surg. Jour.*, p. 453, April 19, 1877.

**The origin and signification of giant cells.** As shown also by other observers, DR. G. WEISS finds that giant cells have no special signification, and are not characteristic of tubercle. He has found them in healthy tissue. His conclusions are: (1) Giant cells are formed by the fusion of several small cells, (2) The small cells thus forming them are granulation cells, (3) Giant cells are never transformed into connective tissue or blood-vessels, but always undergo fatty degeneration, even when they appear to be in the best conditions for living. *Arch. f. Path. Anat. und Phys.*, t. 68.

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## INFLAMMATIONS; ACUTE AND NON-CONTAGIOUS.

JAMES C. WHITE, M. D.

**Erythema multiforme universale.** DR. BEHREND reports the case of a nursing woman, in whom the eruption began in the form of papules upon the face accompanied by fever, chills, and pains in the joints. On the second day the efflorescences appeared also upon the hands and forearms, and later over nearly the whole surface of the body, the palms and soles being the only regions wholly spared. Upon the lower legs, which were œdematous, in the midst of the ordinary papular efflorescence there was a well defined eruption of large nodules of erythema nodosum. Upon the mucous membrane of the cheeks and soft palate, which was generally reddened, as well as upon the inner surface of the labia majora, there was an eruption of small papules. All forms of the efflorescence disappeared in the usual manner, excepting that upon the labia, which were transformed into shallow ulcers. No cause of the occurrence of the affection could be ascertained,

and the reporter is not disposed to refer this or other cases to a reflex origin, although there were sore nipples at the time. He calls attention to the resemblance presented by the eruption upon the face during the first day to that of variola, and later by the whole efflorescence with the accompanying angina to an acute papular syphiloderm. *Vierteljahresschrift. für Derm. und Syph.*, IV. Jahrg., p. 363.

**Erythema.** DR. LAILLER, of St. Louis, in a lecture *de L'Erythème*, enumerates other affections with which it might be confounded, and describes briefly the ordinary varieties of the affection, but adds nothing of value to our previous knowledge concerning it. *La France Médicale*, Oct. 3, 1877.

**Erythema as a result of malaria.** DR. VOLQUARDSSEN, of St. Louis, reports a case of erythema nodosum, which was developed during a primary attack of intermittent fever, ran a short course and disappeared. Excepting an aggravation of the painfulness of the tumors during the periodic hot stages, as would naturally be expected with the increased cutaneous circulation, there was no other apparent connection between the erythema and the other affection than coincident. Dr. Volquardsen also describes a case of erythema papulatum with accompanying intense febrile disturbance, both of two days duration. *Schmidt's Jahrb.*, Jahrg., 1877, No. 7.

**Erythema nodosum and its relations to tuberculosis.** DR. OEHME, of Dresden, contributes an article upon this subject, and gives an analysis of eighteen cases of the former affection, seventeen of which were in females. He calls attention to the constant occurrence of fever as the most important symptom of the prodromal stage, in which, and in the later periods of the disease, the temperature often rises to 39° and 40° C. It is to illustrate the possible connection of the affection with tuberculosis, that he reports the case of a girl nearly 16 years of age, of healthy family, in whom a typical erythema nodosum developed itself, and ran a course of three weeks. With it there was a moderate degree of bronchitis in both lungs. Six weeks after recovery, miliary tuberculosis of the membranes of the brain, pleura, lungs, liver, and kidney, was developed, which proved fatal in eight days. Dr. Oehme regards the occurrence of these two affections as more than fortuitous, for Uffelmann has reported seventeen cases belonging to tuberculous families, in three of which tuberculosis subsequently established itself. The latter is inclined to recognize a special form of the disease which warrants an unfavorable prognosis, and which deserves, he thinks, the title "ominous." Oehme, however, discovered nothing distinctive in the cutaneous manifestations of such cases, but would regard every case seriously, occurring in feeble, anæmic persons, or in those belonging to tuberculous families. He considers the peculiar efflorescence to be due, not to inflammation of the lymph

vessels, embolism, or infarct, but to a vaso-motor neurosis. *Archiv der Heilkunde, XVIII. Jahrg., Heft. 5.*

**Erythema nodosum.** POSPELOW reports the case of a woman in whom, in addition to the ordinary efflorescence upon the arms and legs, there was developed at the same time similar nodules upon the soft palate, the gums, tongue, and upper lip. Some of them had lost their epithelial covering, others had broken down and formed painful, crater-shaped ulcers with a yellow base. The largest of them were of the size of a pea. The reporter regarded them as of the same nature as the cutaneous disease. *Viertelj. für Derm. und Syph., IV. Jahrg., p. 250.*

**The etiology and pathology of urticaria.** DR. LASSERRE in his inaugural thesis recognizes four classes of urticaria. 1. Produced by direct irritation of the skin. 2. By irritation of the gastro-intestinal mucous membrane. 3. In consequence of surgical operations. 4. A septicemic form.

1. The contact of certain plants of the genus *urtica*, the direct action of dry or moist cold, pressure, etc., may produce the disease. To explain this form, the author suggests that the terminal extremities of the cutaneous nerves have been more or less vividly impressed, and serve as the point of departure of a reflex action, which is followed by a vaso-constrictive action of the vaso-motors of the cutaneous capillaries.

2. The ingestion of certain substances, (oysters, eggs, fish, mushrooms, mussels, honey, bitter almonds, strawberries, cucumbers,) may, by their action upon the gastro-intestinal mucous membrane, give rise to this pseudo-exanthem. The author finds a sufficient explanation of this form in a reflex action, the starting point of which may be the irritation of the branches of the pneumo-gastric and sympathetic, which are distributed along the whole course of the digestive canal.

3. The traumatic forms of urticaria have not been long recognized. Their etiology may be explained as the preceding variety. A wound, however light, may irritate the terminal extremities of the cutaneous nerves, and by a reflex action determine an urticaria.

4. M. Verneuil was the first to call attention to the relation between urticaria and septicemia. He states that in pyohæmia the skin becomes sometimes the seat of various exanthematic eruptions, which are not very common, and which are the herald of approaching death. *Le Mouvement Médical, No. 13, 1877.*

**Quinine eruption.** KÖBNER reports a case of a woman, in whom a rash resembling scarlet fever was produced, by taking even small and single doses of quinine. The outbreak was preceded by a chill, nausea, vomiting, headache, and fever. A few hours later an erythema, accompanied by œdema and injection of the conjunctiva appeared upon the face, and soon became

universal. It was attended by great burning and itching. After a week, during which the fever continued, the quinine was omitted, and the erythematous efflorescence subsided. Desquamation continued however for two months. Subsequently the eruption again appeared after a dose of little more than two grains, continuing for four days, and was followed by a desquamation of three weeks. Again a dose of a grain and a half provoked an attack of the same sort, but of shorter duration. The eruption was at one time slightly papular on the legs. [It has long been known, that workers in quinine laboratories are liable to eczematous inflammations of the skin, of parts not only exposed to the dust of the preparations, but of other parts not thus exposed; that those also engaged in the liquid processes of its manufacture, are affected by acute dermal inflammation as well. Some of them are so strongly disposed to such affections, according to M. Chevallier, as to be obliged to give up their occupation. We are sure that we have seen acute affections of the skin aggravated in several instances by the administration of quinine, and in two cases, an obstinate papular eczema in patches excited into existence by it.—*Rep.*] *Berlin Klin. Wochenschr.*, May 28, 1877.

Two other cases are reported by HEUSINGER. The eruption was seated mostly upon the face, and resembled the papular form of erythema exudativum multiforme. There was also a considerable œdema of the parts. In one of them there was a vesicular efflorescence like herpes. *Berlin. Klin. Wochenschr.*, June 18, 1877.

**Erysipelas treated by silicate of soda.** ALWARENGA reports that he has used this soluble glass in forty-eight cases of erysipelas with good and rapid effect. The cases, which were of all forms of the disease, disappeared on an average in four days and twenty-two hours, whereas ordinary cases run a course of eight or nine days. The material is first neutralized with an alkali, if it has an acid reaction, and is then diluted with seven or eight times its weight of water. The parts affected are to be painted with the preparation daily, morning and evening, which is allowed to dry upon the skin. After four or five days, when the fever, redness, and swelling have disappeared, the substance is removed by laying cloths wet with emulsion of sweet almonds upon the parts. Applied to the sound skin, the silicate produces the sensation of cold, contraction of its tissues, and lowering of its temperature. *Il Raccoglitore Med.* No. 8, 1877. *Allg. Med. Central Zeitung*, May 12, 1877.

**Carbuncle treated by hypodermic carbolic acid injections.** DR. CLEVER reports the case of an old woman, with a carbuncle seven or eight inches in diameter, seated over the right tuber ischii. It was purple, very painful, and discharged a clear, red fluid. He injected daily into five different parts of the tumor a Pravatz syringe full of a two per cent. carbolic acid solution.

This was repeated four days. On the second day, the patient was able to get out of bed and sit up. The discharge ceased on the fifth, and the patient made a rapid recovery. *St. Petersb. Med. Wochenschr.*, July 14, 1877.

**Anthrax ending fatally.** A case of anthrax of the upper lip is reported, which terminated fatally. In the opinion of the attending physician, death was the result of a phlebitis, extending from the seat of the anthrax to the facial veins, and thence to the sinus of the dura mater by the ophthalmic vein. *L'Année Médicale*, March, 1877.

**Etiology of malignant pustule.** M. COLIN made a communication to the Academy of Medicine, Paris, upon the subject of the *maladies charbonneuses*, in opposition to the views of Pasteur, maintaining that the bacteria in the blood in these affections are the result, not the cause of their existence, and that the chemical changes in the blood are the cause of their virulence. These changes he finds to be,—1. The blood tends to become fluid, as if a ferment rendered the plasma incapable of forming coagulable fibrin. 2. Its plasma undergoes osmotic modifications, in consequence of which it filters through vessels, serous membranes, and ganglionic tissues. 3. Its globules tend to lose their form, become soft, stick together easily, and allow a great part of their contents to escape. 4. The coloring-matter, the hæmo-globuline, is changed both physically and chemically; it diffuses itself in serum, in intestinal and bronchial mucus, and stains the endocardium, serous membranes, and many of the tissues. *L'Union Médicale*, Aug. 2, 1877.

**Herpes iris.** FUCHS reports an interesting case of this disease, which affected primarily the conjunctivæ, later the lips, sides of the tongue, and inner surfaces of the cheeks, and finally, seven days after its beginning, the hands, elbows, and feet. The membranes, which formed upon the mucous surfaces, attained a thickness exceeding five mm., consisted of epithelium and round exudative cells, embedded in a reticulated fibrous stratum. *Klin. Mon.-Bl. f. Augenheilkunde. Vierteljahresschrift für Derm. und Syph.*, IV. Jahrg., p. 244.

**Acute pemphigus.** BARTHEL and PADORA report cases of acute pemphigus; the former, a single instance which ran its course favorably in fourteen days, the latter an epidemic observed in Pavia. Padora believes not only in the existence of this affection, but in its contagiousness also. *St. Petersb. Med. Wochenschr.*, 1876, No. 1. *Giorn. Ital. delle Mal. Ven.*, II. p. 9, 30.

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## HYPERTROPHIES AND ATROPHIES.

LOUIS A. DUHRING, M. D.

**Multiple cutaneous horns.** BÖTGE describes two cases of multiple horny growths. The first was a man aged 60, who had six horns, four being on the nose, the largest of which was 1 ctm. (about  $\frac{1}{2}$  inch) long, and 3 mm. (about  $1\frac{1}{2}$  lines) broad, and two smaller ones seated on the left cheek near the eye. It is stated that they grew within a month.

The second case was that of a girl of 19, who in her second year had an extensive eruption, which was followed by wart-like growths. The lower portion of body, from crest of ilium down,

was studded with a great number of isolated and grouped horns of various sizes. Both gluteal regions were thickly and quite symmetrically set with them. The right extremity showed a considerably larger number of horns than the left. Below and close to the navel there was a horn 16 ctm. (about 6 inches) in height, while on the right labium there was one which was but a trifle shorter. The horns were composed entirely of epidermis cells, those near the base containing nuclei, while those at a distance were without nuclei. Some of them contained blood, but blood-vessels were nowhere to be found within the growths, nor did they contain any enlarged papillæ; on the contrary their bases were flat, and the papillæ beneath obliterated. About the periphery however, they were hypertrophied, but in place of standing upright, they were turned down on themselves in an outward direction. In one instance the growth sank into the skin after the manner of a corn. *Deutsche Zeitschrift für Chir.*, 1876, Bd. VI. *Viertelj. für Dermatologie und Syphilis*, Heft. I. und II., 1877, p. 259.

**A case of a bearded woman.** HARDAWAY reports a very interesting and quite unique case of this anomaly. The subject was a single lady, 22 years of age, 5 feet 6 inches, in height, and inclined to "embonpoint." Her physique and mental characteristics were thoroughly feminine. The genitalia are reported as being normal, and the mammary glands large and well developed. The voice was soft and agreeably modulated. Menstruation began at 18, and has since been regular and painless. Up to the age of 18, not the slightest indication of the deformity manifested itself, but coincidently with the establishment of menstruation, she noticed that an undue amount of lanugo of a light color, and silky in texture, began to grow upon all of the regions usually occupied by the beard. She now used a depilatory, after which the hairs became stiff and strong, and of a dark-brown, blackish color; and in time coarse, heavier, and more profuse than is usual even with men. The growth was thickly and uniformly set on the lip, chin, cheeks, and submaxillary regions. There was no abnormal growth of hair on the body or limbs. The hair of the head was black, of fine texture, in ordinary amount, and quite long. It did not encroach upon the forehead, temples or neck. The patient had never shaved, but had used a depilatory, as stated, for three years. There was no history of any maternal impression, nor was there any unusual development of hair in either mother or father, or in any other member of the family. The case was at the date of the report, being very successfully treated by electrolysis, each hair being operated on separately. A large number of hairs had been satisfactorily and permanently removed. A detailed description of the method of operation is promised at an early day by Dr. Hardaway.

Another case of well marked hirsuties, occupying the upper lip of a German woman, aged 32, is referred to as having been under the observation of the reporter. The growth in this instance was

confined to the upper lip, and was sufficiently abundant as to form a respectable mustache. *St. Louis Med. and Surg. Jour.*, Nov., 1877.

**Congenital ichthyosis.** LÖCHERER details the case of a child born at full term, of a healthy mother, who had previously had three children. The infant when born was entirely covered with a leathery coating, with here and there bleeding fissures, which rapidly increased in size and number. The skin felt like hard leather, and was from one-eighth to three-sixteenths of an inch in thickness, and was yellowish in color. The rigidity of the skin had interfered with the development of the fingers and toes, and of the features of the face. The nose projected but slightly beyond the line of the face, and seemed to consist only of nostrils. The mouth was open and remained so. Two red swellings—everted eyelids—indicated the place of the eyes. The hands and feet were greatly swollen without being fissured. The fingers and toes were rudimentary. The child lived two days. *Aertzliches Intelligbl.*, July 11, 1876. *London Med. Record*, Oct. 16, 1876.

**A case of sclerema.** DICKINSON reports a case of sclerema in a boy, aged  $3\frac{1}{2}$ . Up to the time of the attack, there had been no disease of the skin, and the general health had been good. The disease came on suddenly, the patient one day stating that his face was hard, and that his eyelids were half closed. The face and body then were hard down to the loins, but the thighs, legs, and arms were natural. Skin was natural in color. The boy did not complain or seem ill. The next day there was swelling over legs, thighs, arms, and hands, with hardness. Upon admission to the hospital, the skin was almost everywhere hard and solid to the feel, like "frozen fat." It was hardest about the cheeks. The eyelids were not very hard, but they could not be more than half opened; they were not puffy. The forehead was hard, and the scalp hard and immoveable. The color of the face was scarcely abnormal. Next in hardness to the cheeks, came the backs of the arms and forearms. The fingers and palms were natural. The front of the breast was harder than the back. There was no itching. Sensation was normal. The temperature was  $98^{\circ}8$ ; skin generally dry, except palms and soles; lips harder than natural, but of normal color. The patient was unable to open mouth fairly, and could not protrude tongue a quarter of an inch. The tongue was hard, smooth on the surface, was not thicker than usual, but felt infiltrated with some hard material. There were no glandular enlargements. Urine 1.028, acid, and clear; no albumen, but a trace of sugar. After a month the patient began to improve slowly, under from five to ten drops of wine of antimony, twice daily. Warm baths were also given.

Dr. Dickinson, however, is not of the opinion that the improvement is attributable to either of these remedies. Seven months

after the commencement of the disease, during which time the patient was under observation, he had regained his health, a very slight induration remaining about the face and scalp.

[The disease here, though occurring in a very young subject, is manifestly one of scleroderma adultorum. Its sudden appearance, general history, and spontaneous recovery within the year, are interesting points.—*Rep.*] *Obstetrical Journal*, Vol. IV., p. 451.

**Scleroderma adultorum.** HALLER describes a case of this disease occurring in a girl, aged 19. The menses had been irregular for a year, and had been absent for eight weeks, when the affection suddenly made its appearance over the parotid region, lower jaws, neck, breasts, shoulders, and arms. She began to improve after a course of six months treatment, which consisted mainly of baths and of various inunctions. Later, she quite recovered with the exception of some induration of the skin over the parotid gland and lower jaws. *Berlin. Klin. Wochenschr.*, April 2, 1877. *London Med. Record*, July 15, 1877.

**Slowly advancing scleroderma attended with cardiac and gastric disorders.** HARLEY believes the atrophy in the case he reports, to be due to depression of sympathetic (vasomotor) nerve power; and that the functional disturbance of the heart and stomach may be ascribed to the same cause. He regards the case as one of slowly advancing paralysis of the sympathetic system of nerves generally, and that the disease is manifested at the periphery, by the atrophy of the connective tissue, and nearer the centre, by the grave disturbance of the circulating and digestive functions. He concludes that the scleroderma, in the case under consideration, is "the direct result of atrophy *pari passu* of the blood-vessels, and of the lacunæ and canaliculi of the connective tissue, converting thereby, the soft, moist, open, and well-nourished net-work, into a hard, comparatively dry, close, and ill-nourished tendinous tissue." *Royal Med. and Chir. Soc. Trans. Lancet*, Jan. 27, 1877, p. 129.

**Scleroderma with sarcoma.** HOWE reports the case of a girl 9 years of age, on whose tibia the disease had begun three years before, after a contusion of the part, and occupied the right leg and thigh. A large ragged ulcer, extending from the knee-joint down along the inner side of the leg to the ankle, made its appearance, which in a short time changed into an exuberant, fungous mass, nearly six inches in a vertical diameter, by four transversely. The leg was amputated at the middle third. The growth was found to be a malignant sarcoma. The scleroderma does not appear to have been examined with any great care, for the subject is dismissed with the statement, that "the indurated skin was found to be made principally of connective tissue." *N. Y. Path. Soc. N. Y. Med. Jour.*, Dec., 1876.

**Elephantiasis of the penis.** DUFFY gives the notes of

quite a remarkable case. The patient (the age is not reported, nor is it stated whether he was white or black) was apparently in robust health, and had never had any disease of the genitalia. Two weeks before, the penis had become erect and had so remained, without interval of relaxation, up to the time he came under notice. At that date the organ was of average size, and exhibited no symptoms of disease other than the persistent erection. Although the penis was not painful, either at this time nor at any subsequent period, it was in such a hyperæsthetic condition that all moving had to be avoided. At the end of two weeks the erection was still present, and the organ had increased in size. Half way between the corona glandis and symphysis pubis, the circumference measured seven inches. The circumference at this point was greater than elsewhere, the organ having a somewhat spindle form. After this the penis increased rapidly in volume, growing equally in all its parts. The skin soon became so distended and tense, that to avoid rupture a lateral longitudinal incision was made on either side. In three months the circumference of the organ measured twelve inches, at which time it was amputated by the loop of the galvano-cautery applied closely to the pubis. The stump healed kindly. Concurrent with the growth of the penis, the glands in the right inguinal region became gradually enlarged, from the size of a pigeon's egg, the size they possessed when the patient was first seen, to the dimensions of the two fists when the amputation was performed. The patient had not noticed any glandular swelling previous to the erection, nor were the glands of other regions of the body at any time involved. The temperature remained normal. The patient became despondent, and lost flesh and appetite. A slight intercurrent attack of pleuritis occurred. The inguinal glandular enlargement began to go down soon after the operation. Two months later the patient was sinking, apparently from mere inanition and anæmia. The glandular swelling had by this time entirely disappeared. The man died shortly afterwards. No autopsy.

The amputated penis was examined microscopically by the committee on morbid growths, who reported an increase in the size of the papillæ of the cutis, with thickening of the layer of epithelial cells covering the same. A transverse cut of the vessels showed "their lumina much diminished in size," and the connective tissue surrounding them increased. No nerves were found in the section. Trans. Phil. Path. Soc. *Phil. Med. Times*, Dec. 23, 1876.

**Elephantiasis scroti.** GOODMAN reports the case of a large tumor of elephantiasis Arabum of the scrotum, upon which he operated successfully. The patient was a native of Fiji, otherwise healthy, and forty-five years of age. The growth, which was pear-shaped, extended to within about three inches of the ankles, and had a circumference of forty inches. The several steps of the

operation are minutely and closely recorded. The tumor after removal weighed forty-two pounds, without taking into consideration the weight of the escaped fluids. There was little or no supuration, nearly the entire wound healing by first intention. *Lancet*, Dec. 23, 1876, p. 889.

**Congenital elephantiasis of the foot.** PASCHAL writing from Mexico, reports an interesting case of congenital enlargement of the foot, which continued to increase in size until the age of six and a half years, at which time the foot was amputated. The tissues were all greatly hypertrophied. It is reported that "the foot perspired a great deal, and kept the joints and folds of the skin constantly irritated." The foot was amputated just above the ankle joint, the patient making a good recovery. It weighed five pounds; and measured from heel to end of great toe eighteen inches; from heel to instep twelve inches. The length of the great toe, from metatarsal articulation, was eight inches; of second and third toes from metatarsal articulation, six inches; round metatarsal bones seventeen inches; round tarsal bones sixteen inches; from malleolus to malleolus twelve inches. *Richmond and Louisville Medical Journal*, Dec. 1876.

**Treatment of elephantiasis Arabum.** WILLIS speaks of having seen good results in elephantiasis Arabum, in the early stages of the disease, from local pressure combined with the internal use of iodide of potassium, quinine and iron. In the more advanced cases such treatment is of little or no avail. In regard to tumors of the scrotum in the male and of the labia in the female, removal by amputation is recommended as being comparatively safe and easy. Dr. Willis' experience relates to Japan. *Lancet*, May 5, 1877. p. 670.

**Leucoderma in the United States.** Dr. THOMAS F. WOOD, of Wilmington, N. C., under the above title, reports the case of a very black negro man, aged 40, who had typhoid fever in 1866 from which he recovered very slowly. The following year, being still in poor health, patches of leucoderma made their appearance symmetrically on his hands, and arms, then on his face and lastly on his body. For several months, in the years 1867 and 1868, his eyes were so intolerant of light, and his skin so sensitive to the hot sun, that he was compelled to give up his occupation, which was that of a sawyer. Towards the end of 1873 his face and hands had become almost as "bright as those of the brightest mulatto;" also the scalp in large patches as well as the hair. In October, 1876, he was again examined, when it was discovered that re-deposit of pigment was taking place in the same order in which it had been absorbed. Steadily since the above date there has been a re-deposit of pigment going on, so that in some of the earlier spots the color is nearly that of the sound skin surrounding it.

In the same communication there is a portrait of another case,

a negro woman who has been the subject of leucoderma for thirty years. The hair, neck, anterior surface of the trunk, arms, hands and fingers are almost entirely white. *Medical Examiner*, July 19, 1877.

**Circumscribed atrophy of the skin.** KOLACZEK records a case of circumscribed atrophy of the skin, in a girl aged twenty. At the age of eleven she fell against a stove, which accident was followed two years afterwards by a yellow spot, situated on the right side of the forehead near the median line. It increased gradually in size, the skin becoming thin, shining and wrinkled. The subjacent bone was also partially atrophied. The region affected corresponded to the course of the frontal artery and vein, and middle branch of the frontal nerve. The sensation of the part was diminished. *Deutsche Med. Woch.*, No. 32, 1876. *Lond. Med. Record*, Oct. 16, 1876.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### SYPHILIS OF THE NERVOUS SYSTEM.

E. C. SEGUIN, M.D.

**Some cases of syphilitic chorea.** The two cases forming the basis of ALISON's report were not observed by the author. They and the other cited from Zambaco's collection hardly carry conviction on the question of the existence of a "syphilitic" chorea. The first case was probably one of pre-paralytic chorea, a very different symptom from common chorea. The "therapeutic test" upon which the author places great reliance is hardly infallible, since non-specific diseases are cured by iodide of potassium. *Amer. Jour. Medical Sciences*, p. 75, July, 1877.

**Paralysis of the mental branch of the inferior dental nerve caused by syphilitic lesion of the maxilla.** FOURNIER relates a case in which, during the later stages of syphilis, anæsthesia and analgesia appeared in the distribution of one inferior dental, without neuralgia. In a week, under iodide of potassium, relief was obtained, and a complete cure soon followed. He refers to another case recorded by Zambaco in his book on syphilitic nervous affections, p. 250. [The reviewer has met with two cases of this rare seat of syphilitic disease. In one, seen in the practice of Dr. Edward Seguin, there was only anæsthesia of the lips and mucous membrane, in the other seen in consultation with Dr. Bulkley, there was neuralgia of the inferior maxillary nerve.—*Rep.*] *Gaz. Hebdomadaire*, p. 804. Dec. 22, 1876.



**General pseudo-paralysis of syphilitic origin.** In this important contribution, FOURNIER endeavors to establish the proposition that the so-called general paresis occurring in syphilitic subjects is only a very rough imitation ; that paralytic symptoms predominate, symptoms appear in a capricious and irregular order, the special fibrillary contractions of the facial and lingual muscles are absent, there are no well defined exalted notions, and lastly in the pseudo-general paralysis, syphilitic cachexia is present. F. considers the special lesion in these cases to be meningeal sclerosis, though of course there may also be other lesions, such as gummata, arteritis, etc. The bearing of these notions upon an exact diagnosis are self-evident, and the importance of precise diagnosis is perhaps nowhere so great in prognosis and treatment as in syphilitic disease of the nervous system. Dr. F. had, however, been preceded in this field by Dr. Mickle, *vide infra*. *Le Prog. Méd. Oct.* 13, 22, and 27, 1877.

**Notes on syphilis in the insane.** These three articles by DR. W. G. MICKLE, comprise a report of excellent cases of so-called syphilitic insanity, in the earlier and later periods of syphilis, an acute *critique* of the rather loose way in which the term "syphilitic insanity" has been used, and lastly an able attempt to establish the differential diagnosis between true general paralysis of the insane and the pseudo-general paralysis observed in syphilitics. He would distinguish the latter by : 1. Distinct history or symptoms of syphilis ; 2. Preceding cranial pains, nocturnal and intense ; 3. Exaltation less marked, less persistent, and perhaps less associated with general maniacal restlessness and excitement than in most cases of general paralysis ; 4. Sometimes by such complications as palsies of one or several cranial nerves, or hemiplegia, paraplegia, etc., having the character and course of syphilitic palsies ; 5. The greater frequency of optic neuritis, early amaurosis, deafness, local anæsthesiæ, vertigo, or local rigid contraction ; 6. The affection of articulation is paralytic rather than paretic, and usually speech is not accompanied by any facial or labial tremors ; 7. By cerebral or spinal meningitis, or pachymeningitis : 8. By the variety of the motor and sensory symptoms, their capricious association or succession, and transitory character, and by the absence of the general progressive muscular paresis of the other disease ; 9. By the effect of anti-syphilitic treatment. Dr. M. also states that the faradic contractility of the muscles of the extremities becomes considerably and progressively lessened, while in syphilitic cases it is normal or not much impaired. This is a point well worthy of further exact study. *Brit. and Foreign Med. Chir. Review*, July, 1876, p. 161, Oct. 1876, p. 439, and April 1877, p. 444.

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- Cerebral syphilis. *Lyon Méd.*, p. 561, Aug. 19, 1877.
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## SYPHILITIC DISEASES OF THE EYE.

RICHARD H. DERBY, M. D.

**Syphilitic neuroses of the eye.** BULL gives the notes of five cases of syphilitic neuroses of the eye. The author emphasizes the fact that these specific neuroses show a marked tendency to relapse, and that the later they occur, the more unfavorable is the prognosis. *Amer. Journal Med. Sciences*, Jan., 1877, p. 62.

**Syphilitic keratitis and notched teeth.** BURNETT, in a series of notes on Parisian ophthalmology, speaks of specific keratitis as extremely rare in the Parisian clinique, and the notched teeth of Hutchinson he but seldom saw in the children. He refers to the better hygienic condition of the Paris poor as an explanation of the rare appearance of this form of inherited syphilis. *The Medical and Surg. Reporter*. Sept. 16, 1876.

**Chancre of the conjunctiva.** H. DIETLEN describes a case of specific primary lesion of the conjunctiva. The patient was a physician, who first noticed the lesion three or four weeks after examining a woman with syphilitic condylomata. Five or six weeks later there was roseola and enlargement of the parotid, and

submaxillary of the same side with the primary sore. The peculiarity of the conjunctival lesion was chemosis, swelling of the tarsus and external canthal ligament, induration and discoloration of the outer half of the fold of transmission. Later there formed a firm, hard cicatrix at the affected point. Dietlen further tabulates eighteen cases of interstitial keratitis. In fifty per cent. of these, congenital syphilis, and in fifty-five per cent. acquired syphilis was established. *Klin. Monatsblätter für Augenheilk., XIV., Jahrg.*

### **Subcutaneous injections of calomel in syphilitic iritis.**

GIULIO SALTINI contends that the rapid cures of syphilitic iritis by subcutaneous injection of calomel are not due exclusively to the anti-syphilitic action of the remedy. He details five cases of syphilitic iritis where the affection yielded most rapidly to the subcutaneous injection of calomel in the temple, without any apparent effect being produced upon the general syphilitic symptoms. He reports in addition four cases, one of simple keratitis, two of ulcerative keratitis, and one of rheumatic iritis, in all of which relief followed the use of calomel subcutaneously. From his observations he draws, among others, this conclusion: "The great advantages derived from injections in the temples, in the cure of syphilitic iritis, should most probably be referred to a local action of calomel, whether solvent or revulsive, or to both actions combined, as Dr. Quaglino has judiciously observed, and as is also proved by the efficacy above reported of this new proceeding in the cure of non-syphilitic ocular affections." *Annali di Ottalmol. Vol. V., Fasc. 2 and 3. Monthly Abstract of Med. Sciences, Dec., 1876, p. 561.*

**Changes in the optic nerve in syphilis.** SCHOTT found in the case of a woman who died with all evidences of syphilis, beside a marked swelling of the brain, the right optic nerve of double its normal size, from chiasma to the optic foramen. The cells of the neuroglia were increased both in number and size. *Arch. f. Augen u. Ohren Heilkunde. V. Seite 409; Centralbl. f. die Med. Wissensch., 28 April, 1877.*

**Gonorrhœal ophthalmia in a new-born infant, with remarks on the relations of gonorrhœa to syphilis.** DR. F. T. PORTER describes a case of blenorrhœa of the new-born child, where the mother had a few weeks before confinement acquired syphilis, and shortly after had a roseola. From the fact that the father admitted only that he had a gonorrhœa, and showed no evidence then of syphilis, the author argues that the father with simple gonorrhœa gives the mother syphilis, and the mother gives the child gonorrhœa, *ergo*, the two poisons of gonorrhœa and syphilis are identical. There is no evidence that the affection of the child's eyes was anything more than blenorrhœa. The simple statement of the father, and the absence of any present evidences of syphilis in him, are slender facts on which to build a theory. *Med. Press and Circular, April 11, p. 285.*

"Brevity, indeed, upon some occasions, is real excellence."

—CICERO, BRUT. 13.50.

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# ARCHIVES OF DERMATOLOGY.

APRIL, 1878.

Original Communications.

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## THE PATHOLOGY OF SEBORRHŒA.<sup>1</sup>

BY ARTHUR VAN HARLINGEN, M.D.

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SOME time ago, while investigating the pathology of certain affections of the skin in which the epithelium plays a prominent part, I had occasion to examine microscopically the product of disease thrown off in the various forms of seborrhœa, as found in different parts of the body. Somewhat to my surprise I found the epithelium to present a different character in some cases of the affection known as seborrhœa sicca capitis from that shown in the other forms of seborrhœa. In a brief account of these investigations published last year<sup>2</sup> I expressed a doubt, suggested by the results of my microscopic examinations, as to the propriety of calling this affection seborrhœa. "It does not" I said, "consist essentially in an excessive flow of abnormal sebum, but in the exfoliation of the epidermis, (from the stratum corneum) mingled indeed with sebaceous matter to a greater extent than is the case in the other squamous affections of the scalp, but nevertheless presenting epidermis as its principal pathological product." I found myself unable at that time to follow up this statement with any further details, but I propose in the present paper to take the subject up once more, and, while noting some facts in the patholo-

<sup>1</sup> Read before the American Dermatological Association, Sept. 4th, 1877. For discussion thereon see Archives of Dermatology, January, 1878, p. 58.

<sup>2</sup> A Contribution to the Pathology of Epithelium. *Am. Jour. Med. Sci.*, July, 1876.

gy of seborrhœa in general, to attempt in particular the demonstration of the essentially non-seborrhœic character of the seborrhœa sicca capitis of Hebra and others, at least in some of its forms. In order to do this I shall first offer some remarks upon the histology of the sebaceous glands with their product. I shall then give the results of examination in those affections which are beyond question seborrhœic in character. Having presented the sebaceous glands in their normal and pathological condition, I shall examine the product of disease in the affection particularly in question, and by a comparison of this with the normal type of seborrhœic disease, and also by reference to the histological facts stated, shall endeavor to establish my proposition. Finally, I shall adduce the evidence of other writers who have arrived at the same conclusions with myself, through studying the affection from a somewhat different standpoint.

#### HISTOLOGY OF THE SEBACEOUS GLANDS.

The sebaceous glands may be regarded as involutions of the skin, or, in some cases, of the hair sacs. That all the layers of the skin however do not take part in this involution will appear, if we picture to ourselves a normal gland seen in section, as described by the histologists. We observe that the outer portion of the gland is composed of an external coat of connective tissue, continued in the case of free glands from the corium, in other cases continued from the hair sac. (Kölliker). This may be termed the gland sac, and its interior with the exception of a small central cavity is filled with epithelial cells, directly continuous with those of the stratum Malpighii, of which the most external, that lie in contact with the gland sac, resemble the deeper cells of the mucous layer, except only that the nucleus is more distinctly visible. Those that are situated more internally first become filled with small fat molecules, and then with larger fat drops that surround and conceal the nucleus and cause the cells to increase in size. The cavity of the sebaceous gland is occupied by an amorphous mass of fatty matter, and the debris of numerous cells. (Biesiadecki). The stratum corneum does not take any part in the formation of the gland itself. As it dips down into the funnel-shaped opening of the sebaceous sac it appears to become more and more attenuated, and either ends at the neck of the gland proper, or perhaps lines a portion of the neck. This absence of the stratum corneum in the structure of the sebaceous gland would be a matter of indifference in reference to the present subject, if the same views prevailed as formerly regarding the genesis of the horny cells from those of the stratum mucosum. Kölliker<sup>1</sup> says: "The formation of the cutaneous sebaceous matter resembles in many respects that of the cuticle. The young, easily soluble cells at the bottom of the

<sup>1</sup> *Manual of Human Histology.* Syd. Soc. Edinb. Vol. I, p. 227.

glandular follicles may be compared to the malpighian cells of the epidermis, and the less soluble ones of the secretion filled with fat to the horny plates." But the recent researches of Langerhans<sup>1</sup> prove that the stratum corneum is absolutely separated from the stratum mucosum by the stratum lucidum of Oehl and Schrön, and that the latter alone forms the germinal layer for the horny cells of the cuticle. We can not therefore regard the cells of the sebaceous secretion as homologous with those of the horny layer, and if in any affection supposed to involve the sebaceous glands, we find under the microscope cells from the stratum corneum, we are driven to suppose, either that these are adventitious accompaniments of the seborrhœal affection, or, if the horny cells are in great excess, that the sebaceous material has been poured out to some extent, in connection with an affection essentially epidermoidal in character.

#### PATHOLOGY OF THE SEBACEOUS GLANDS.

Proceeding now from the histology of the sebaceous gland to its pathology, let us examine the product of secretion in those inflammatory conditions in which this is abnormal in quality or quantity or both. If we express the plug-like mass of a comedo from the gland containing it, and cutting off the outer third of its length, examine the remainder under the microscope, we should expect to find all the elements of the sebaceous secretion characteristically displayed. I have done this with the following result : a number of comedo plugs prepared as above were digested for some days in ether, and the solid matter remaining was stained with aniline, and examined under the microscope. The major part of the field was occupied by cells, with some granular debris. These cells were colored darkly by the aniline with the exception of a large vacuole in the centre which remained quite light. The surrounding cell contents showed advanced fatty degeneration, being composed of fat granules and globules. *No cells resembling those of the horny layer were observed.*

In seborrhœa oleosa we should also expect to find the true glandular secretion, only poured out in excess, and with the addition of a certain number of horny cells derived from the general surface, or perhaps from the funnel-shaped apertures of the glands. Having scraped the oily product lightly from the surface of the nose in a well marked case of seborrhœa oleosa, I placed a portion upon a glass slide, and after treating it with aniline examined it microscopically. The field as in the case of comedo was largely occupied with deeply stained epithelial cells, their contents showing advanced fatty degeneration. The nucleus which was usually small and light-colored, was occasionally shrunken and surrounded by a bright areola. The cell contents consisted entirely of granules or globules of fat. In some cases

<sup>1</sup> *Archiv. f. Mik. Anat.*, 1874, s. 741. Abst. in *Archives of Dermatology*, Vol. I, No. I, p. 61.

the cell outline was dim or jagged as if the cell was about breaking down into fat globules and debris. There was much granular matter in the field with *a few* unmistakeable horny cells.

I suppose that *seborrhœa oleosa* is a precisely analogous affection to *comedo*, the difference between them being that in the latter, the chemical constitution of the sebum is altered, while in *s. oleosa* this is unchanged, being merely increased in quantity. Here then we have in two undoubtedly *seborrhœic* affections no cells resembling the horny cells of the epidermis, excepting that in the case of *seborrhœa oleosa* a few are encountered evidently adventitious in their occurrence.

There is one variety of *seborrhœa sicca*, which is essentially the same disease as those just mentioned. This is found in its most characteristic form on the chest and back in the shape of nummular or annular patches made up of a reddish base, surmounted by yellowish-brown, fatty, pellicle-like scales, occasionally massed together to form a greasy coating. I have examined the product of disease in this variety of *seborrhœa* with the following result : The disease from which the specimens were taken was composed of patches and rings of yellowish-brown oily scales, of a pearly, greasy lustre, and having a doughy feeling when pressed between the finger and thumb. They contained so much oily material as to leave large stains in the bit of paper on which they were lying. Treated with aniline and water the cells colored pretty well, though they were somewhat difficult to stain, owing to the repulsive action of the commingled oil. Under the microscope the cell contents were found to be decidedly granular. In some cells minute oil globules could be observed ; the cell outline was frequently indistinct. Many cells contained a nucleus which in some cases appeared shrunken, and was contained within a vacuole : in others the place of the nucleus was occupied by a vacuole alone.

Thus far all is plain. The product of disease is essentially the same in *comedo*, *seborrhœa oleosa* and *seborrhœa sicca corporis*. I have reason to believe that certain forms of *seborrhœa sicca capitis*, those in which the eruption is similar to that described as dry *seborrhœa* of the body, present the same microscopic appearances. I have not, however, had an opportunity of examining these. It is when we come to examine that variety of *seborrhœa*, which is characterized by the formation of fine dry powdery, or pearly white scales, constituting a branny desquamation of the scalp, that we find decided differences in the microscopic appearances presented. The following notes of an examination of a case of this kind will show just what these differences are : The scales taken from the scalp of a young girl, who had suffered a long time with severe "dandruff," were macerated for some weeks in ether, and then stained with carmine. Under the microscope the cells were sharp in outline, without distinctly granular contents ; no sign of fatty degeneration. Most of the



cells contained large distinct nuclei, much lighter in color than the protoplasm.

It is very evident, I think, that we have here a different product from that remarked in the first three observations. There we had the typical product of the sebaceous gland, the granular cell, sometimes complete, again breaking down, and finally broken into granules and globules of oily matter. Here we find nothing of the kind. The cells are those of the horny layer, and although differing in appearance from the epithelial cells of the horny layer thrown off in eczema squamosum and psoriasis, yet evidently belong to the same stratum. We have in this form of disease, to which the term seborrhœa can, I think, no longer be properly applied, something intermediate, pathologically speaking, between seborrhœa sicca and eczema or psoriasis. For this the term pityriasis or pityriasis simplex might properly be employed. In times past this term was used to denote a large number of affections having a desquamation of the epidermis as their chief feature, but being distinct in other respects. In the natural reaction from this confused nomenclature, we have come of late to confine the term to the disease known as pityriasis rubra alone. The field, therefore, remains clear for the introduction of the title pityriasis simplex, to denote an affection whose pathology and clinical aspects alike exemplify the idea conveyed by this term.

At the time the examinations were made, which led me to the conclusions above stated, I was unaware that similar views, as to the existence of a true pityriasis, had been reached by others. I have since ascertained that such views have been sustained, in opposition to those of Hebra, by Pincus<sup>1</sup> and Piffard<sup>2</sup>. Pincus, after stating Hebra's views, says, that while admitting the value of the latter's observations, he cannot subscribe to the conclusions drawn from them. Pincus collected the scales from the scalp in a number of cases of ordinary dandruff, dried them, and after weighing them carefully, digested them in ether, weighed the sediment, and examined it microscopically. The result of seven such estimations showed an average loss of three-fifths the entire mass. The remaining two-fifths were epidermis. On two occasions Pincus had an opportunity of observing pityriasis capitis complicated by seborrhœa. The seborrhœa appeared, and ran an acute and severe course, so that the old pityriasis alone remained at the end of fourteen days in one case, and at the end of three and a half weeks in the other case. Having examined the scales in one case every third day, and in the other every second day, during the course of the disease, he found that when the disease was at its height, the proportion of pure epidermis in the scales was one-ninth to one-eleventh of the entire mass. During the latter part of the disease, as it was disappearing, the

1. *Das Zweite Stadium der Alopecia pityrodes*. *Virchow Archiv.*, Bd. 41, 1867, p. 322.

2. *Diseases of the Skin*, New York, 1876, p. 192.

old proportion of two to five was again observed. Pincus goes on to say, that where the seborrhœic matter poured out is almost fluid, and the skin looks as if covered with oil, the proportion by weight of epidermis must be much smaller. He inclines to the plan of calling by the designation seborrhœa the disease heretofore known by that name, while the affection just alluded to should be called pityriasis, with the understanding that this designation does not involve a denial of the existence of something more than a mere increased desquamation of epidermis.

Piffard, speaking independently of Pincus, and making no reference to his statements, arrives at a similar conclusion. He says<sup>1</sup>: "Upon microscopic examination, the scales (of pityriasis) will be found to be constituted chiefly of horny cells, with a varying, sometimes very slight, amount of entangled sebum." That there is an affection, which may with propriety be called seborrhœa sicca, Piffard admits. For this disease he prefers the name *acne sebacée*. Piffard gives a picture of the microscopic appearance of the cells in pityriasis, which resemble precisely those seen and noted by me.

Finally, the facts above stated may be formulated as follows :

1. The sebaceous secretion is derived from fatty metamorphosis of the enchyma cells of the sebaceous glands. These cells are homologous with those of the stratum mucosum of the skin. They have nothing in common with the cells of the horny layer.

2. Seborrhœa is a disease of the sebaceous glands, characterized by the pouring out of an increased quantity of sebum, more or less altered in chemical and physical composition. In comedo and seborrhœa sicca, properly so called, the secretion is condensed to a fatty consistency, while in seborrhœa oleosa it remains in an oily state. In each of these affections, however, microscopic examination shows epithelial cells in a state of more or less complete fatty degeneration, and breaking down into granular debris. Horny cells are only found adventitiously.

3. Certain forms of disease, heretofore commonly classed as seborrhœa sicca, should properly be removed from the category of diseases of the sebaceous glands, since the pathological product in these cases is not sebum, but epithelium, from the horny layer of the skin. Any sebum which may be present is a mere accompaniment of the epithelial product. For these cases the designation pityriasis, or pityriasis simplex, would seem appropriate.

1. *Loc. cit.*, p. 193, note.

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## ON THE IMMUNITY OF CERTAIN MOTHERS OF CHILDREN AFFECTED WITH HEREDITARY SYPHILIS.\*

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IN the study of syphilis, the questions respecting the pathological relations of progenitor and progeny, are both numerous and interesting. The literature of the disease is rich in historical details of discussions originating in connection with these questions, in the names of eminent authors who have sought to elucidate the truth by scientific research, and in the collection of clinical cases which seem to have a bearing upon one side or the other of the points in controversy. Some of these problems need but be named to suggest the dialectic turmoil which they have occasioned. Such are the questions respecting the various stages in which transmissibility of the disease may occur by heredity, the relative share of the paternal and maternal organisms in such transmission, the contagiousness of the lesions of the inherited disease, and the possibility of the gradual extinction of the power of the parent to entail syphilis upon his or her offspring.

Recent papers and public utterances by such authors as Kassowitz,<sup>1</sup> Diday,<sup>2</sup> Hutchinson,<sup>3</sup> Drysdale,<sup>4</sup> Taylor,<sup>5</sup> Caspary,<sup>6</sup> and Oewre,<sup>7</sup> have redirected attention to one phase of certain of these questions, which it is here proposed to consider. When a syphilitic husband becomes the father of a child affected with hereditary syphilis, and his wife prior to conception has never suffered from the disease, what is the latter's share in the pathological result? Has she become affected by the so-called syphilitic semen? Is the disease of the child due to her infection exclusively, if she is by the fact of conception alone necessarily diseased? If infected directly by her husband after the occurrence of conception, has she subsequently transmitted the disease to her offspring, and if so, at what period of gestation? And, finally, if she has never suffered from such direct infection, has

\*Read at the first annual meeting of the American Dermatological Association, Niagara Falls, N. Y., September 5, 1877. For discussion thereon see Archives of Dermatology, January, 1878, page 64.

1. Die Vererbung der Syphilis. *Braunmüller, Wien*, 1876.
2. Annales de Dermatologie et de Syphiligraphie, T. 8, No. 3, p. 161.
3. Consult a Review of the Debate on Syphilis at the Path. Soc. of London. *The Doctor*, May 1, 1876, p. 89.
4. Observations on Hereditary Syphilis. *The Doctor*, Feb. 1. 1877, p. 39.
5. A contribution to the study of the transmission of Syphilis. *Archives of Clinical Surgery*, Sept., 1876.
6. On healthy mothers of children who have Hereditary Syphilis. *Vierteljahrsschft. f. Derm. u. Syph.*, Hft., 4, 1875.
7. Etiology of Hereditary Syphilis. *Nord. Med. Arkiv.*, V. VII., f. 3.

the fœtus transmitted to her the disease which originated in the male parent? In other words will the theory of *choc-en-retour*, originally propounded by Ricord, and quite recently boldly advocated by Diday,<sup>1</sup> stand in the light of the closest scrutiny? It is a theory which sustains the proposition, that at every period of intra-uterine life, the ovum, embryo or fœtus, originally infected by the father, may transmit the disease to the mother, who has hitherto escaped the peril.

The special phase of this question, to which it is here intended to direct attention, is that which respects the real or apparent immunity of certain mothers placed in the conditions described. I have to offer no demonstration of the correctness of any view—no original investigation which might furnish a clue to the solution of the problem. Why then discuss it at all? An excellent response is embodied in the paper read by Dr. Robert Barnes, during his late visit to this country, before the American Gynecological Society.<sup>2</sup> Said he: "When one has nothing to teach, when there is no problem one can expound, the best thing to do is to set forth the problems that exercise his thoughts as clearly as he can, to put his speculations in the interrogative form, by appealing to a never-failing passion in the human breast—the desire to unfold a mystery, to penetrate a secret, to set others at work to help in carrying out the injunction of Bacon, to 'question Nature.'"

It is evident that the wife of the syphilitic husband, and the mother of the syphilitic child, must be in one of three conditions. Either she (1) has unmistakable syphilis; or, (2) has syphilis which is incapable of recognition by ordinary means—that is, does not display the symptoms of the disease whereby it is usually recognized; or, (3) enjoys entire immunity. In the first case, that viz., where unmistakable symptoms of syphilis are displayed by the mother, there is, of course, no question of immunity. Infection has then occurred either (a) prior to conception, or (b) subsequent to that date, and, in the latter event, either by direct transmission from the husband, or by the indirect method claimed by the advocates of the theory of *choc-en-retour*.

I. Cases in which direct infection of the mother has occurred prior to her last pregnancy, do not have a special interest for us in this connection.

The possibility of the occurrence of direct maternal infection, after transmission of hereditary syphilis from the father to the child, does not seem to have greatly troubled the authors upon this subject. And, while such a possibility has only an indirect bearing upon the question of immunity, it requires consideration, since it enables us to explain certain apparently anomalous cases. A woman, healthy up to the day of conception, produces an ovum which is fertilized by her syphilitic husband. In accordance with

1. Loc. cit.

2. Trans. Am. Gyn. Soc'y, 1877.

the view of Kassowitz, Taylor, and others, I believe that she is not thereby necessarily infected. If this be either proven or admitted, it must follow, that she is, during the remainder of gestation, just as liable to contract the disease from her husband as she was before she became pregnant. It can scarcely be doubted that such a transmission not infrequently occurs. In a paper to which reference has been already made, Diday gives the record of twenty-six cases, in which as many mothers first displayed the symptoms of syphilis during gestation. Concluding that the syphilis, in each of these cases, originated with the fœtus, he does not even stop to consider that those who differ with him respecting the source of the maternal disease, are not necessarily restricted to the antepuerperal period, in explaining her condition as the result of direct contagion. If the mother then is healthy during the first month of the gestation of a syphilitic fœtus, certainly she may acquire the disease directly from her husband in the next and succeeding months. So that the whole argument based upon the date of appearance of maternal symptoms, is, upon this hypothesis, utterly without value, unless all sources of direct contagion throughout the entire pregnancy be rigidly excluded. Why then does she not exhibit a chancre? This is the weakest part of the argument presented by Diday.

Let me here quote one of his observations on this point: "First," he remarks, "the authors state positively that they have searched for, but not discovered, chancre." But here may be urged the objection briefly mentioned by Kassowitz,<sup>1</sup> "that every trace of the primary lesion upon the mucous membrane of the female genital tract disappears often after several weeks." Recall, in this connection, the forcible language in which Fournier<sup>2</sup> refers to the initial period of the primary lesion in women: "It is," he says, "the smallest, most superficial, most benign, most insignificant in appearance of all possible lesions. It is not something: it is, so to speak, less than nothing. So much so that on the first occasion or occasions when one is called upon to decide as to its chancrous character \* \* \* one is always mistaken, and it is impossible not to be mistaken." The very latest utterance of the same Author<sup>3</sup> upon this subject is as follows: "Statistics show that the evidences of contagion after marriage are the most superficial accidents, often misunderstood, and to which no importance is attached." Surely in this view it becomes absurd to designate by the fanciful title of *syphilis d'emblée*, that condition in which there has merely been a non-discovery of chancre. It is not only true that a large proportion of all chancres in married women escape detection, but also generally known that an equal proportion of lesions designated as "chancres" by those who are not specially expert in their recognition are, in fact, mucous

1. Loc. cit.

2. Leçons sur la Syphilis, Paris, 1873, p. 83.

3. Jour de. Méd. et. de Chir. prat. July, 1877, p. 303.

patches of the genitals. These explanations are justified by the language employed by Diday in the article to which reference is here made. He says: "If the syphilis comes directly from the husband, it would first have appeared at the vulva or the mouth—would it not?—for it is only at these points that contact is effected in married life." Notice the words, "at the vulva or the mouth." No allowance is here made for the occurrence of chancre upon the collum uteri; and yet in 1873 \*Schwartz,<sup>1</sup> after studying chancres of the cervix, concluded: (1) That chancres of the neck of the uterus are less rare than is generally believed; (2) that they possess peculiar characteristics during only a very brief period of their evolution; (3) that they have a very distinct tendency to a spontaneous and rapid cure; and (4) that they require no active treatment.

Again, it is claimed by Diday that in some of the twenty-six cases reported by him, the husbands had syphilitic lesions that were "evidently quite innocent, so far as madame was concerned, for either in consequence of their seat or character they were not transmissible (e. g. an acne capitis or a palmar syphilide); or were incapable of producing by contact the first lesions which appeared in the mother (e. g. pustules upon the hairy scalp, etc.)."

Now, in the argument which Diday reposes upon this fact, he deliberately ignores the possibility of direct infection from the husband's blood. It is difficult to understand how such an oversight can be made by an author with such decisive and unequivocal evidence at hand. Shall we pronounce a man innoxious for his wife, or a wife for a husband, when either has, it may be, only a squamous syphiloderm externally, but from whom the merest prick of a pin, or a scratch, will give exit to a drop of fluid blood that is potential in the transmission of the disease? How often is the person of the male brought into contact with uterine (I might say menstrual) blood during the unconsciousness of sleep with his partner; or in consequence of that stimulating coitus wherein the menstrual epoch is often surprised into precipitancy! Often, too, by friction, or, as a result of what Fournier calls, "the multiple contacts of a life in common," the mucous membranes of the male suffer a slight rent or abrasion, from which a drop of blood escapes to the surface. This part of our subject may be dismissed with a final criticism of Diday's statistics. These latter present in tabulated form: the names of the several observers; the duration of precedent cohabitation without pregnancy, the wife remaining healthy; the condition of the husband at the moment of conception; the epoch in gestation when maternal syphilis appeared; the nature of the first symptoms of the latter; and, finally, the issue of the pregnancy. Observe that in each of these twenty-six cases the author would have us believe that the maternal disease was due exclusively to the product of conception. And yet the author's argument is almost

1. *Etudes sur les chancres du col utérin.*, Paris, 1873, p. 134.

exclusively concerned with the condition of the husband and wife, the study of the fœtus and child—*fons et origo* of all the evil—being dismissed in a single foot note. In three cases nothing whatever is known of the condition of the fœtus. Twice the word "abortion," is merely given. Twelve times we find the "abortion" stated, with the single addition of the period of gestation when it occurred. One child, born at term, is stated to have been "healthy." Five were reported healthy at birth, and subsequently developed symptoms which are merely named. Two only were born displaying lesions which are described in equally unsatisfactory terms. For the purposes of science such details are absolutely valueless, and legitimately result in the absurd attempt to affix the stigma of infection upon a *corpus delicti*, the observation of which is concluded by the single record of "healthy." Dr. R. W. Taylor<sup>1</sup> has well described the course to be pursued in such investigations. "The truth is," he remarks, "that facts have too often been ignored in this study, through the bias for a theory. Whatever side the observer takes, it is my firm conviction that he should have all the facts relating to the three persons."

II. Recurring now to the second of the three alternatives presented at the outset of this discussion, we have for consideration, the wife of the syphilitic husband, free from the disease prior to conception, but who, becoming thereby infected, presents no symptom of the disease. In such cases we are confronted, not with a fact, but with an hypothesis. It is claimed that women under such circumstances are affected with a modified form of the disease, which does not betray itself by the recognized phenomena of constitutional syphilis. In order to meet such an hypothesis surely we might be justified in waiting for the establishment of positive proof. I am aware that it may be claimed that the extrusion of a syphilitic fœtus, may be considered in itself a sufficient symptom of maternal disease, to be regarded as a single explosion of the newly acquired diathesis, the system meantime enjoying such a lull in the pathological storm as is not unfrequently noted in the ordinary course of the disease. But this is satisfactorily answered in the history of those cases which have been carefully watched from the first by competent observers for a period of years, during which no other symptoms were declared.

Let us however note, from the standpoint of the gynecologist and the obstetrician, the *a priori* reasoning, which is based upon the recognized pathological tendencies of the puerperal female.

Lecame, Becquerel, Rodier, Andral and Gavarret have all demonstrated that in pregnancy there is a constant diminution in the number of the red corpuscles of the blood; and here we recognize a condition which usually accompanies, and assuredly

1. Loc. cit.

would favor the development of a syphilitic cachexia. We note, besides, in the pregnant condition a remarkable tendency to the development of the larger glandular structures, some of which degenerate in consequence of the artificial hyperæmia, the thyroid, mammary, uterine, and salivary glands being aroused to unwonted activity, while the spleen often remains permanently hypertrophied. The function of the sebaceous and sudoriparous glands, the liver and the kidneys becomes greatly augmented. The lymphatic system, stimulated in an unusual measure, often produces a rapid disappearance of fat cells. Melasma of the face and abdominal surface, as well as of the integument of the eyelids, may result from such a free deposit of pigment, that the latter may occasionally be removed by the finger from the skin. Were syphilis present, would it not infallibly betray itself in some perversion of these exalted functions ?

But how much weight such an argument deserves, can be determined far better by considering the post-puerperal condition which succeeds delivery. We discover that woman in this state is actually capable of originating in her own person a disease whose contagious character is unreservedly admitted. And yet, enormous as is the mass of literature on the subject of puerperal fever, its relations to scarlet fever and erysipelas are not as yet defined. Compare with this striking fact the testimony of Ceely,<sup>1</sup> and other vacciniculturists, and we are not surprised to learn that spontaneous vaccinia almost invariably originates in newly-delivered cows. The bull, the sturk, and the dry heifer are very rarely found affected with the disease.

Even upon such a cursory view as this we are led to the conclusion that the puerperal and post-puerperal states are favorable to the development of a contagious disease, characterized by marked alterations in the blood, the glandular and the lymphatic systems, and displaying, at least in its earlier period, cutaneous exanthemata.

III. Referring now to the last of the three alternatives heretofore stated, we come to the consideration of the question of the possibility of complete immunity for the mother of the syphilitic infant. And it is just here that clinical evidence is most convincing. Even those who claim that the mother may be infected by her unborn child, are forced to admit that there are *some* mothers who escape ; while the advocates of the doctrine that intra-uterine infection is impossible, consistently claim that no exceptions to the rule can be established.

The three cases, a brief abstract of which is subjoined, are by no means unique in character. They serve merely as illustrations of a general truth, the records of which are daily multiplying. The record is made up from notes taken at the time of observation of each patient, details not pertinent to the issue in question

1. Consult Seaton's Handbook of Vaccination, London, 1868, p. 48.



being omitted. In the first case, no evidence is obtainable relating to the products of conception but the facts narrated are sufficient to establish a degree of antecedent probability that will be allowed to have weight.

CASE I.—Mr. G——, a Chicago dealer in grain, aged 36 years, states that when a resident of St. Louis, in 1868, he had a single ulcer upon the glans penis, which appeared about one week after intercourse with a woman of the town. The sore was cauterized by a physician of that city, who also subjected the patient to internal treatment. This, however, did not prevent the subsequent appearance of an eruption upon the body, and sores in the mouth, which were relieved during the subsequent year, whereupon, being apparently free from disease, he married. In 1871 he applied to me, and was then suffering from an indolent inflammation of the matrix of one toe nail, disseminated pustulo-crustaceous lesions of the scalp, a perforating interdigital ulcer, and one also upon the dorsum of the right foot, and severe rheumatoid pains in the lower limbs. His cachexia was extreme, and his appearance highly indicative of exhaustion from toxæmia. After a severe attack of albuminuria, during which the urinary precipitate was generally equal to one-fifth of the bulk of the specimens examined, granular epithelial casts and pus cells appearing under the microscope, the patient slowly recovered a fair degree of health under the influence of the most energetic restorative and anti-syphilitic treatment.

The wife of this gentleman is a remarkably healthy looking lady, 32 years old, with a red hue of the cheek which is not often to be seen in the western lake states. She has aborted spontaneously four times since her marriage, always between the second and third months of pregnancy. In consequence of the anxiety of the husband, she has been kept under my observation for six years and a half, and during this time, though repeatedly and carefully examined by me, she has never exhibited the slightest symptoms of syphilitic disease.

CASE II.—H. M., an Irish janitor, aged 34 years, states that in 1868, he contracted a sore upon the prepuce, for which he was treated in London, and which was followed by an eruption upon the skin, and the development of "knots" around his neck. The ensuing year being, as he thought, relieved of his disorder, he married. On the 5th of June, 1871, he came to me for relief of a serpiginous ulceration, affecting the cutaneous surface of the penis, and encroaching upon the scrotal region. This disappeared under appropriate treatment, but, in September of the same year, he returned with a white, elastic, painless tumor, as large as a pigeon's egg, just above the left olecranon process. This speedily degenerated, leaving a perforating ulcer of corresponding size, with undermined edges and foul base, which at one time threatened the integrity of the elbow joint. This improved rapidly under anti-syphilitic treatment, till cicatrization resulted. Since

then, he has repeatedly suffered from excruciating nocturnal pain in the tibia, for which large doses of the potassium iodide were requisite to procure relief. Fully understanding the situation, this man begged me to have supervision of his wife's health, and she has since consulted me for every ailment during a period of six years. In 1869 she was delivered of a still-born child by an irregular practitioner of Chicago, who soon afterward removed from the town. Details of the condition and appearance of the child, cannot be procured.

She was slow in recovering from this confinement, and consulted Prof. Daniel T. Nelson, of Chicago, who found that she was suffering from subinvolution of the uterus, but could detect no symptom of syphilitic disease. For several weeks consecutively she was examined with the speculum, for the purpose of making topical applications. In 1874, her health having meantime been completely restored, she was delivered in May of a puny male infant, having an earthy discoloration of the skin, and the typical appearance of wrinkled senility. The child was so unsightly that for weeks it was an object of disgust to the relatives of the mother. Between the second and third months a brownish red macular exanthem developed upon the surface of the body—thickly dispersed over the abdomen, back and lower limbs, as well as the palms of the hands and the soles of the feet, accompanied with snuffles and patches upon the labial angles. Under the use of inunction, and by the aid of the abundant breast milk of the mother, the child was restored to a fair degree of health. Upon the appearance of an inelastic, painless and prominent tumor over the left temporal region one year afterward, the treatment was renewed, and the persistent swelling reduced. The child, now three years old, is puny and delicate in appearance.

In January of 1875, the parents meantime remaining healthy, a third pregnancy resulted in the birth of a healthy male infant, which from the first presented the greatest physical contrast with his brother. The child is now eighteen months of age, and is in every respect well developed and vigorous.

I have carefully and repeatedly examined this mother during the six years past, frequently employing for that purpose the speculum, and exploring the vagina, os and cervix uteri, without discovering any symptom of syphilis in any part of the body. She has a moderate goitrous enlargement of the thyroid gland, which is not manifestly larger than before the marriage.

CASE III.—Mr. W. L., a hatter, aged 29 years, states that when living in New York eight years ago, he had a single ulcer of the sulcus develop in eleven days after suspicious intercourse, the sore becoming indurated, and remaining unhealed for several weeks. Meantime the glands in his groin became enlarged, and his throat excessively sore, when he was mercurialized to profuse salivation by a practitioner of that city. This was followed by the development of "boils" about the neck. During the next

two years he was treated for an eruption upon the surface of the body, and in the third year thereafter he sustained relations with a mistress, who bore him an infant that survived its birth but nine days. He inspected the body of this child, both before and after its death, and noticed that it was completely covered with blotches.

The relation between the parties was then discontinued and the former mistress, receiving an honorable offer of marriage, became united to a presumably sound husband. Her health has been unimpaired since the birth of the illegitimate child, and she has since borne two healthy children. Mr. L. determined these facts by personal communication with all the parties.

On the year succeeding the dismissal of his mistress, this gentleman married a healthy young lady of New York City, aged nineteen years. Seven months after the wedding she was delivered of a still-born child. This led to her knowledge of the husband's infection.

Becoming pregnant a second time, the child was carried to term, but died in three months after its birth of some wasting affection, under the care of Dr. J. Lewis Smith, of New York.

A third pregnancy resulted in the birth of a healthy female child, now two years and a half old, who has never exhibited traces of the parental disease.

Between the date of this last and the ensuing pregnancy, the father was prostrated by an obscure paralytic affection, which temporarily deprived him of power over the muscles of articulation and the organs of speech. This attack had been preceded by a severe rheumatic affection. He recovered from both disorders under treatment.

The fourth pregnancy resulted in the birth of a male infant, which developed an eruption between the second and third months; and the parents were so concerned regarding it that they at once consulted my friend, Prof. H. A. Johnson, who established a diagnosis of hereditary syphilis, and referred the case to me. I found the child suffering from a severe diarrhœa, with a copious macular exanthem over the surface of the body, but chiefly upon the lower extremities, including the soles of the feet, where it was exceedingly distinct. The lesions were coppery red in hue, and were, upon the buttocks especially, commingled with pin-head-sized papules and scales. This child also had the advantage of the mother's abundant breast milk, and recovered completely, though very slowly, under a mercurial treatment.

I have had the mother of these two children under personal observation for a period only eight months, but during that time have frequently examined her without discovering any symptom of the disease from which her husband suffered. She has a few acne papules upon the face, as have a large number of other blonde women. It will be seen that she has been four times pregnant in five years, and this has proved a severe tax to her constitution, and one well calculated to develop any latent tendency to a dysthetic process.

The three women, whose cases are briefly given above, have never had genital lesions, external adenopathy, loss of hair, ulcers of the buccal, tonsillar or pharyngeal membranes, symptoms indicative of visceral lesions, or eruptions upon the skin, with the single exception noted. None have received anti-syphilitic treatment. The first, under observation for six years and a half, may be regarded as a type of the large-framed, rosy-checked representatives of her sex. The second, whose unmarried sister I have frequently examined by conversation, states that she is descended from a family in which there is no trace of hereditary disease. The third wife is a fair picture of the pale and slender American girl, with the anæmia so commonly observed after years of lactation, broken rest, and anxiety regarding the health of her offspring.

The following facts are noteworthy:—

1. That the paternal history in each case was obtained either by actual observation or narration, prior to the examination of wife and child; and was therefore not extorted from a reluctant witness, as is so frequently necessary in securing details of hospital patients.

2. That the absence of what has been termed "intense syphilitic symptoms" in the living children, was undoubtedly due to the stage and persistent treatment of the paternal disease.

3. That, in the second case, the sequence of healthy and unhealthy children has a significant connection with what appears to have been a relapse in the father of his syphilitic symptoms.

4. That the incidental immunity of the mistress, in the same case, who subsequently produced healthy children with her husband, though reported at second hand, has yet its value in studying the innocuousness of the syphilitic fœtus in utero.

The comparative study of generation in the vertebrata teaches most conclusively that the product of gestation is not an essential part of the organism of either parent, but is the completest instance of a *tertium quid*. "In the oviparous animal," says Dr. Granville,<sup>1</sup> "the formative force or energy is embodied in the egg. After extrusion from the oviduct, the ovum is so completely self-sustained that it may be taken away and hatched by the heat of another animal body, or by an artificial apparatus indifferently, and the developmental process will proceed under either set of conditions, and produce the *transmitted* peculiarities of the bird. The circumstance that in the viviparous animal the ovum is not deposited outside of the body, but normally received into a special apparatus, the uterus, where it can be fed with material for growth, does not affect the essential principle of the method of either development or transmission. This is proved by the curious fact that the fertilized ovum itself may attach itself almost anywhere in the uterus, in the fallopian tube, in the interstitial structures of the organ, and provided only it can

1. Ideation in utero. J. M. Granville, M.D., &c., *Lancet*, Mar., 1877, p. 117.

establish an arterial connection with the mother—not, as we know, direct, but under conditions in which the endosmotic process may be carried on between the foetal and maternal blood, the new organism will live and develop.”

Still more curious proof, is that well known to obstetricians as occurring rarely in extra-uterine foetation, where a fertilized ovum, finding an obstruction in the fallopian tube attached to the ovary, where it had matured, completely traverses the abdominal cavity, and finds lodgment and arterial connection in the fallopian tube of *the other side*. The truth is, that the semen, after its projection from the male urethra, is not more independent of the generator than is the fertilized ovum after separation from its follicle of the generatrix.

Turner<sup>1</sup> has recently called attention to the fact that the fundamental type of the placenta, is a vascular membrane upon the foetal side, upon one face of which is a layer of pavement epithelium, while that on the maternal face of the membrane, is of the columnar type. The complexity resulting from evolution produces finally the highly specialized discoid placenta of man. It is just this distinctly defined partition wall, through which Kassowitz<sup>2</sup> has pointed out that the *porte virus*, the cell requisite to transmit syphilis, cannot pass. The function of the placenta, as Mr. Lawson Tait<sup>3</sup> has recently shown, is that of a lung chiefly, and, he might have added, that of the lung of an aquatic animal; for such the foetus undoubtedly is. But for the accident of its arterial connection, the foetus would also be cold-blooded. In the paper by Mr. Tait, to which reference has been made, he attributes to the amniotic fluid a power to aid in the nutrition of the foetus, and cites an example, in which less than one-fifth of the placenta remained healthy, and yet a well-developed child was born. He regards fatty degeneration of the placenta as of doubtful occurrence, having never observed it in numerous examinations, and believes that the cases reported are instances of molecular degeneration after detachment. He thus utterly refuses to accept the doctrine of syphilitic disease of the placenta proposed by Fränkel,<sup>4</sup> of Breslau, and defined by him as “disfiguring cell-proliferation.”

I desire in this connection to call attention to the singular fact reported by Heller,<sup>5</sup> that in cases of abortion from trichiniasis, no trichinae have ever been found in the foetus, though Fiedler<sup>6</sup> has repeatedly detected trichinae in the blood of affected women.

1. Evolution of the placenta. *Jour. of Anatomy and Physiology*, June, 1877.

2. Loc. cit.

3. Trans. obstet. Soc. of London. Note on diseased placenta, T. 17, 1876, p. 326.

4. See the *Obs. Jour. of Great Britain and Ireland* (Am. reprint) for Oct., 1875.

5. Cyclopædia of the Practice of Medicine. *Ziemssen*, N. Y., 1875, p. 637, Vol. III.

6. *Archiv. der Heilkunde*, V., pp. 5 and 472, 1864.

Again Gusserow<sup>1</sup> injected various solutions of iodine and the ferrocyanide of potassium into the stomach of pregnant guinea pigs, rabbits and dogs for days in succession, without being able to detect these substances in the liquor amnii of the foetus. Frehling<sup>2</sup> produced apnœa of the mother by injecting curara into the jugular vein of rabbits, but could not affect the foetus. These experiments are detailed by Dr. P. F. Mundé,<sup>3</sup> who injected hypodermically from twelve to sixteen grains of morphia daily throughout the pregnancy of a mother, who subsequently bore a healthy child. On the other hand there is abundant evidence to show that volatile and diffusible agents, such as chloroform, can traverse the placental parietes, and produce an influence on the unborn child.

With reference, however, to the transmission of the exanthematous fevers, and of variola in particular, from the mother to the child, we are justified in refusing to accept unreservedly, at least for the present, the doctrines which are now maintained. A strong argument from analogy rests upon this supposed transmissibility, whose weight can be appreciated when it is remembered how fruitful a field to the syphilographer has proved the study of variola. Both diseases may be produced by inoculation in unprotected individuals; and the resulting phenomena in each are, in many respects, analogous. Now even Kassowitz<sup>4</sup> admits that this alleged transmissibility of variola from mother to child has been "demonstrated;" and I submit the following established facts as tending to subvert any such "demonstration:"

1. Variola of pregnant women does not necessarily result in variola of the foetus. Serres<sup>5</sup> alone reports twenty-two cases where non-variolaous children were born of mothers who suffered from small pox during pregnancy.

2. Variola of the foetus may occur when the mother has not suffered from the disease, and this whether she be protected by vaccination or not. Cases where variolaous children were born of mothers, some of whom only were previously vaccinated, and yet who showed no symptom of small pox, are reported by Jenner,<sup>6</sup> Ebel, Kesler, Watron, Deneux, Royer, Bouchut and Chaigneau. It follows from this fact that, even though mother and child simultaneously suffer, each may have contracted the disease from the same third source.

3. Evidence is not wanting to show that mother and foetus may suffer from the same disease at different periods of the one gestation. Bouteiller,<sup>7</sup> of Rouen, has recently reported the case of

1. *Archiv. für Gyn.*, III, 2, 1870.

2. *Archiv. für Gyn.*, IX., 2.

3. *Obs. Jour. of Great Britain and Ireland*, Jan., 1877, p. 206.

4. *Loc. cit.*

5. *Traité théor. et prat. de l'art des Accouch.*, P. Cazeaux, Paris, 1867, p. 437.

6. *Cf. Cazeaux, loc. cit.*

7. *Gazette Obstét.*, July 20, No. 14, p. 222.

a woman, aged thirty-one years, in her third pregnancy, who first suffered from variola, October 24, 1876, and who aborted on the 21st of the subsequent December. The fœtus was covered with a crop of well-developed pustules just at the period of umbilication. Here fifty-eight days elapsed between the two dates—more than double the time necessary to allow for the incubation and maturation of the pustules, even allowing for latency the largest incubative period of sixteen days—that of the natural disease when access is by the mucous surfaces. Pennetier<sup>1</sup> has reported a similar case, where the interval amounted to two months.

4. Variola of the pregnant woman, when the fœtus is spared, confers no immunity upon the latter. Cotugno<sup>2</sup> inoculated two pregnant women, who had discrete small pox, and bore healthy children at term. Each child was successfully inoculated by the author in its third year, the induced variola being in all respects regular.

5. A non-variolous pregnant female may bear twins, one child alone being affected with variola. Such a case is reported by Chantreuil,<sup>3</sup> and is strictly analogous to that of the healthy mother of twins, one child alone having hereditary syphilis. It is from such an occurrence that Kassowitz<sup>4</sup> concludes the mother to have been free from syphilis, otherwise both children would have displayed her disease, and it is difficult to see why the same reasoning should not be applicable to the two cases.

We find then, in short, that a mother may suffer from variola, and her child *in utero* remain healthy; the child may suffer, and the mother be unaffected; one child of twins may alone suffer, the mother being non-variolous; mother and child may suffer from the same disease at different periods of the one gestation; and, finally, the disease of the mother, when the child does not become variolous, confers no protection upon the latter. I have dwelt upon this subject merely because it seems clear that if the trans-placental incommunicability of variola be once established, that of syphilis must assuredly follow.<sup>5</sup>

To return to the question of the immunity of the mother of the child with hereditary syphilis, we are at once confronted with the observation first made by Mr. Abraham Colles,<sup>6</sup> in 1837, that "the woman who has borne a child to a syphilitic father, rarely contracts the disease from the former, and, in any case can never subsequently suffer from it." This is known as the law of Colles,

1. *Union Méd. de la Seine, Infér.* Rouen, April 15, 1877.

2. Cf. Cazeaux, loc. cit.

3. *Union Méd. de la Seine, etc., supra.*

4. Loc. cit.

5. Burton (*British Medical Journal*, Jan. 9, 1875) reports that he has observed several cases, in which mothers were vaccinated during pregnancy, who subsequently bore children that were susceptible to the vaccine virus, showing that intra-uterine transmission of vaccinia does not necessarily occur.

6. Practical observations on the venereal disease, and on the use of mercury, London, 1837.

and it is unnecessary to say that it has been urged as evidence of the fact that the mother's immunity is solely due to her infection. Both Kassowitz<sup>1</sup> and Taylor<sup>2</sup> admit the force of this law—the former contenting himself with the statement that it deserves to be “carefully studied and clearly stated.” He is also candid enough to admit that the exceptions reported by Cazenave in 1847, Brizio Cochi in 1858, and Müller in 1861, are not described with sufficient distinctness.

Caspary,<sup>3</sup> on the other hand, has inoculated with the secretion of syphilis the wife of a husband placed under the conditions described; and obtained only negative results. But the experiment, even though negative in character, is otherwise without value, since the case, as published, renders it probable that the woman was directly infected by her husband; and it is not conclusively shown that she was infected in any other way.

Taking a general view of the immense number of recorded observations, it may well be doubted whether the law of Colles will ever be successfully refuted. Even should a perfectly well authenticated exception be noted, it would almost inevitably receive only that degree of acceptance which men usually accord to the isolated exceptions to established laws. It remains for us, therefore, in my judgment, merely to enquire whether the conceded immunity of the mother is due to her infection.

Were we in position to admit that the lesions of inherited syphilis were non-contagious, the difficulty would at once disappear. Günzberg's<sup>4</sup> cases, however, which were adduced in support of this theory, have utterly failed to counterbalance the preponderance of testimony on the other side of the question. Still, the author has done well by his writings on this subject, in emphasizing the necessity of carefully determining, in every case, where syphilis has been acquired from an infant, whether that infant suffered from infantile or hereditary disease.

A curious illustration of the necessity of making this distinction is to be found in an editorial note published in the *Medical and Surgical Reporter* of April 21, 1877, under the title, “Extension of Colles' Law.” The note is suggested by a case reported by Dr. James McCraith,<sup>5</sup> of Smyrna, in which a syphilitic infant with mouth lesions failed to infect its mother, who suckled it; and yet did convey the disease to its nurse. But, by reference to the original article, it is seen that the child was suffering, not from hereditary, but from acquired disease, having been infected by the kisses of a syphilitic nurse-maid. The details, however, are so loosely reported, that they give rise to the suspicion that the

1. Loc. cit.

2. Loc. cit.

3. *Vierteljahrsschft. f. Derm. u. Syph.*, 4 Hft., 1875.

4. *Oesterrich Jahrb. f. Paeditrik*, J., 1872, B., 11.

5. *Med. Times and Gazette*, Mar. 19, 1859, p. 289



mother ultimately suffered, the author also displaying his confusion of ideas respecting the history of syphilis.

The question then remains : Why does not the infant, whose syphilis is strictly inherited from the father alone, infect the breast of its mother ? "Because the mother has syphilis," is the common response. But suppose we put this response in an interrogative form, or in other words answer the question by asking another : Can the infant, whose syphilis is inherited from the mother alone, infect its father ? Surely till this latter question can be affirmatively answered, no response deserving of the name can be given to the former. Take, for example, the every-day instances of a mother infected with syphilis by a former husband, or by the application of a syphilitic infant of another woman to her own breast, or by any one of the numberless contacts whereby syphilis may be acquired. If she afterward bear a syphilitic child to her healthy husband, can the mouth lesions of the infant infect the father who kisses it, or who comes in contact with it during sleep, as in the case reported by Violet,<sup>1</sup> where the child was by this means infected from the father ? After a careful examination of many reported cases I have failed to find one such instance. It is true that the contact between father and child is much less frequent, prolonged and intimate than that between the breast of the mother and the infant, whose lips are applied to it. Still the negative fact may be considered of sufficient importance to justify its provisional acceptance upon precisely the same plane as the law of Colles. And its importance lies in this, that whereas the suspicion of syphilis is attached to the mother of the syphilitic infant, because her breast is proof against its mouth lesions, no such suspicion can attach to the healthy father of the child, whose syphilis is derived from the mother alone. If no exception to either of these rules can be determined, then we are in position to enunciate a higher and broader law than that of Colles, viz. : that when hereditary syphilis is transmitted to a child by one parent only, the other, remaining free from the disease, cannot be infected by the offspring.

How can such a curious fact, if fact it be, receive an explanation ? Only upon the basis of what is already known of the behavior of the disease in general. The virus of syphilis is intimately associated with an organic cell—a pus, lymph or blood corpuscle. It is as impossible for us to conceive of the virus disassociated from this syphiliferous element as it is for us by experimentation to separate the two. Now in acquired syphilis we find introduced into the economy two foreign elements ; first, the virus, and, second, with that virus, and inseparably associated with it, an organic cell of alien parentage.<sup>2</sup> Admitting that the

1. *Etude prat. de la Syph., infantile*, Paris, 1874, p. 28.

2. In a recent article by Dr. F. R. Sturgis, of New York, entitled, *Etiology of Hereditary Syphilis*, it is assumed that systemic infection occurs by endosmosis into the blood. It is, of course, indisputable that sooner or later the blood in syphilis becomes virulent, but proof is daily accumulating that the lymph

lesions of hereditary syphilis are contagious for all others, we are led to the conclusion that it is the pus cell, the lymph or blood corpuscle, that cannot be successfully implanted upon the parental organism. In other words there is such homogeneity of tissue between progenitor and progeny, that the syphilis carrier cannot be grafted successfully upon the parental stock.

If this be a fact, it merely illustrates what the French call the *unicité* of the disease. Why cannot the secretion of an initial syphilitic sclerosis, for example, be readily employed in auto-inoculation? The answer has been, because such primary lesion is an evidence and result of systemic infection already induced. Yet Auspitz<sup>1</sup> has recently shown by his excisions of such lesions several days old, when constitutional disease did not result, that the entire subject requires further investigation. It can scarcely be doubted that attempts at auto-inoculation with the secretion of these excised sores would have, in the large majority of cases, failed; and yet the excision removed the possibility of systemic disease. This would seem to indicate that the general non-auto-inoculability of the syphilis secretion does not in every case depend upon systemic infection, but rather upon the natural inaptitude of the tissues to sustain a graft from their own stock. And this inaptitude would be far more likely to obtain in hereditary disease, where the cell brood is directly derived from the parent, than in acquired disease, which involves the necessity of a previous introduction of a foreign cell element.

In the discussion of the subject thus submitted, I have endeavored to present the following suggestions:

1. That, if the possibility of the occurrence of conception without maternal infection be admitted, it follows that direct infection of the wife by the husband may occur at any subsequent period of the gestation. Hence the date of appearance of maternal syphilis, cannot be urged in support of the so-called "syphilis by conception."

2. That inasmuch as the blood of the husband is capable of transmitting the disease directly to his healthy wife, the non-contagious character of the lesions exhibited by the former, cannot be urged in favor of his innocuousness during the pregnancy of the latter.

3. That many of the physiological and pathological phenomena of pregnancy, render it highly improbable that syphilis of the mother should exist without external manifestations; there being, channels are the sources of the disease. Maurice Reynaud [*L'Union Méd.*, No. 79, July 7, 1877, p. 31,] recently reported to the French Academy of Sciences the results of the following interesting experiment: he first vaccinated a horse, and produced a local eruption in ten or twelve days. He then established a "true lymphatic fistule" by opening the lymphatic vessels passing from the site of these lesions, collected the lymph, injected it into the jugular vein of another horse, and observed on the sixth day a "magnificent eruption of horse pox" upon the second animal.

1. *Vierteljahrschft. für Derm. u. Syph.*, IV. J., 1 and 2, Hft., p. 101.

Further, evidence of the fact that puerperal and scarlet fevers and erysipelas in the human female, as well as spontaneous vaccinia and equinia, are contagious diseases, connected with and often originating in abnormal puerperal conditions.

4. That the mode of development of the fertilized ovum demonstrates the phase of its physiological independence of the maternal organism, the placenta discharging a respiratory function, and presenting an effectual barrier against intra-uterine infection.

5. That there is evidence to show that not only trichinæ, but various other poisonous organisms are incapable of transmission through the placental parietes; and that the proofs of such transmission in the case of the exanthematous fevers, and variola in particular, cannot be considered as fully established.

6. That the full weight of Colles' law is to be estimated in connection with the question whether the child, whose hereditary syphilis is derived from the mother exclusively, is capable of infecting its healthy father; and, if no instance of this latter can be adduced, a higher law becomes defined, viz.: that the child whose hereditary syphilis is transmitted by one parent only, is incapable of infecting either.

7. That if such immunity be established, it is probably due to the fact that the syphilis bearing cell element cannot readily be implanted upon the soil from which it sprang—a fact illustrated by the infecundity of consanguineous marriages, and the non-auto-inoculability in general of the primary lesion of syphilis.

## A CASE OF TRUE PRURIGO (OF HEBRA).<sup>1</sup>

BY ROBERT CAMPBELL, M.D.

*Physician to the Skin Department, Demilt Dispensary, New York.*

TRUE prurigo, as defined by Hebra, is so rarely seen in this country, that it is desirable to place on record each authenticated case of this disease; and as the patient who forms the subject of this report was observed a number of times, and seen also by Dr. Bulkley and Dr. Duhring, who agreed to the diagnosis, it is thought that it may not be without interest. This, as far as I can learn from current literature, is the second recorded case of the disease occurring in America, the other having been reported by Dr. Wigglesworth of Boston.<sup>2</sup>

Charles S., aged 11, born in New York, of German parents. His father has always been healthy; his mother died of inflammation

1. Read at the First Annual Meeting of the American Dermatological Association, Niagara Falls, September 5th, 1877. For discussion thereon see *Archives of Dermatology*, p. 62, Jan. 1878.

2. *Amer. Journ. of Syph. & Dermat.*, vol. iv, p. 21, 1873.

of the bowels when he was a year old. About two years afterwards his father was married to the patient's aunt, who now has tuberculosis of the apex of the left lung. The boy has one sister and one brother, and four half-sisters. The eldest half-sister, about nine years old, has phthisis, with that exception the remainder of the family enjoy good health. The child had measles when two years of age, and soon after that, the father says, the present eruption made its appearance on the outer side of the thighs, and gradually increased until it occupied the greater part of the body. Sometimes it improves a little, being generally better in summer, than in winter; the eruption has, however, never entirely disappeared. The patient says that he suffered very much, about two years ago, from a sense of oppression when breathing, so much so that he was compelled to gasp when he attempted to take a deep inspiration. At this time he noticed that the glands in the axillæ and inguinal region began to enlarge. The itching caused by the eruption, is excessive and exists to so great an extent that he is kept awake a greater part of the night scratching; the father also states that he (the patient) often scratches the surface during his sleep. The itching is worse on the upper and lower extremities. Nothing definite can be ascertained as to when the skin began to be pigmented.

*Condition, as observed, on August 4th, 1877.*—The patient is of ordinary height, of rather spare build, with dark brown hair, and eyes of the same color. He presents a tired and care-worn appearance; his eyes are sunken; he has a continual frown on his face, leading one to suppose that he had suffered a great deal of pain. On having the clothes removed the entire surface of the skin is found to present a yellowish-brown, pigmented appearance, giving one the impression that the body had not been cleansed in some time. Almost the entire body, with the exceptions to be mentioned farther on, is found to be covered with scattered papules varying in size from a pin's head to that of a small bean. These papules are subcutaneously situated, feeling as if small shot had been placed beneath the skin, they are mostly of the color of the surrounding surface and would often escape notice if the hand were not passed over the skin. The surface presents a harsh, dry and thickened feeling. The hairs, all over the surface of the body, are not so numerous as we would expect to find them in a healthy person, and are found to be broken off and torn out by the scratching. The papules are pierced by hairs.

On examining the patient more in detail, we find the head to be free from eruption, also, that none has ever existed there, but the hair has a dry and harsh feeling, and has lost its lustre. On the forehead and face the papules are rather numerous, existing to a greater extent on the cheeks, and in larger numbers on the right than on the left side, they are here of a reddish hue, subcutaneously situated, and, in some places, slightly elevated. The nose, upper and lower lips, and chin are spared. The skin of the neck, on all

surfaces, is of a yellowish-brown color. On the anterior surface, between the sterno-mastoid muscles, there are no papules, but, on the sides and back of the neck, the points of eruption are quite numerous, although each one is isolated from the adjoining papule.

On the front of the chest, immediately below the clavicles, the eruption is more scattered, the papules being further apart and smaller in size; here they are of the color of the skin, not elevated, and can be more readily felt than seen. The umbilical region and vicinity, is spared. On the lower part of the abdomen, just above the pubis, are a number of papules; in this situation a number of the papules have their summits scratched off, resembling, at a first glance, the appearance seen in phthiriasis corporis.

The upper part of the back is almost entirely free from eruption with the exception of the shoulders where a few papules exist. Further down in the lumbar region, and, on the sides of the body, the papules are quite numerous, especially in the latter situation. All the eruption on this surface of the body is of the color of the skin; the integument of the back and sides of the body is not so deeply pigmented as on the anterior surface.

On examining the upper extremities, the glands in the axillæ are found to be enlarged, those on the left side being larger than in the corresponding situation on the right side. The left arm is free from disease, except the inner side and lower third of the extensor surface where a number of colorless papules, about fifteen or twenty in number, are to be found. On the flexor surface of the forearm, left side, commencing below the anti-cubital space which is spared, are two or three fleshy and colorless papules; these increase in number until at the lower half of the forearm they are very abundant, are larger and are slightly reddened. On the extensor surface of the forearm the elbow is found to be free from eruption; below this point, the papules are very evenly and thickly distributed over the surface as well as on the ulnar and radial borders, existing to a greater extent in the former than in the latter situation. All along this surface the papules are of a purplish red color. On the back of the hand the papules are quite numerous but very greatly obscured by the great degree of pigmentation; the palm of the hand is spared. The skin on both surfaces of the forearms is very harsh, considerably thickened, and the hairs are thin and broken off. The surface is marked by a number of scratched papules, in some places, more particularly on the extensor surface, blood crusts have formed. On closer examination we find a number of white marks scattered between the papules, apparently superficial cicatrices left by a previous crop of papules. These white cicatrices exist on both surfaces of the forearm and on the dorsal surface of the hand. Toward the wrist, and on the back of the hand, the skin is very deeply furrowed, approaching nearly the character of fissures. The finger nails are bulbous, resembling those seen in patients affected with phthisis. The

eruption is distributed on the right arm and forearm, similarly to that of the left, but not to so great an extent.

On the buttocks the papules are rather abundant and colorless ; they exist to the same extent on both sides. The glands in the inguinal region are very much enlarged and here, as in the axillary space, those on the left side are larger than on the right side. The penis and scrotum are quite free from disease. On the thighs there are a few colorless papules, the inner surface being almost entirely spared. The knees and popliteal spaces are also free from disease. The legs are almost entirely covered with papules, large in size and purplish red, causing an appearance, in some places, similar to that seen in parts where the flow of venous blood has been obstructed. The marks of scratching are very numerous and the blood crusts are much larger than those seen on the upper extremities. The regions over the tibialis anticus and peronei muscles, and over the tibia are the parts where the eruption and marks of scratching exist to the greatest extent, and, in these situations, the fleshy nature of the papules can be best felt. The surface of the skin is rough and harsh, feeling like sand paper, or a nutmeg grater, a feeling described as peculiar to the disease. The white superficial cicatrices, mentioned as existing on the forearms are to be found here ; there is, also, a disposition to desquamation as shown by the fine scaling existing on the extensor surfaces in this part. Papules exist on the dorsal surface of the foot, but the skin is so harsh and the pigmentation so great, that it is with difficulty that they can be felt or seen ; this surface of the foot is also marked by very deep furrows. The white cicatrices are to be found here also ; the plantar surface of the foot is free from eruption. The toes are illy developed and the nails are clubbed. The left side is effected to a greater extent than the right.

One peculiar feature in this case is, that with the exception of the face, the eruption exists to a greater extent on the left, than the right side of the body.

He was ordered :  $\mathcal{R}$  Acidi Carbolicì,  $\mathfrak{z}$  ss ; Olei Morrhuæ,  $\mathfrak{z}$  iv. M. One teaspoonful three times a day ; locally,  $\mathcal{R}$  Olei Cadini,  $\mathfrak{z}$  ss ; Ol. Morrhuæ,  $\mathfrak{z}$  ivss. M. To be applied every night.

*August 22d.* Does not feel any better, the itching is about the same. Ordered to continue the same internal treatment ; locally, the quantity of oil of cade was doubled in the mixture.

*Sept. 2d.* The patient still complains of intense itching and says that the mixture containing oil of cade only relieved him for the first few days after using it.

The papules are all of them colorless, probably because the day is cooler than when he was first seen. There is more eruption to be seen on the neck, and it exists between the sterno-mastoid muscles. On the forearms, flexor surface, the papules are more evenly distributed and occupy the whole of the surface. The marks of scratching and blood crusts are also more numerous both on the

upper and lower extremities. The degree of pigmentation is, however, less.

Ordered to continue the carbolic acid mixture internally, and locally to apply unguentum picis liquidæ, every night.

In conclusion, for further particulars of this interesting and distressing affection, I would refer my readers to the able description of the disease given by Hebra, in his work on diseases of the skin.

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## TWO CASES OF VERY LATE HEREDITARY SYPHILIS.\*

BY L. DUNCAN BULKLEY, A.M., M.D.

*Physician to the Skin Department, Demilt Dispensary, New York; Attending Physician for Skin and Venereal Diseases at the New York Hospital Out-patient Department.*

VERY little is said in the writings on syphilis of manifestations of the hereditary form late in life, and as a rule the mind connects the inherited disease with the congenital and infantile phenomena, which are familiar to all. The two following cases are here presented, not because they are so very unusual or remarkable, but, possessing many features of interest, they may serve to introduce a discussion of the subject which may result in much profit. It is unnecessary to enter into the literature of the subject, but suffice it to recognize the fact that cases of late hereditary syphilis have been reported from time to time, so that it is fully established that the disease acquired by hereditary transmission may have manifestations many years after the period at which they commonly appear, namely, the first six months of life.

CASE I.—Last spring I was consulted by a very intelligent and well-posted practitioner of this city, who for a long time had had charge of the skin clinic at one of the dispensaries, in regard to a private patient, who had what he thought to be lupus; and he wished my opinion in reference to the advisability of using the actual cautery. No doubt had yet occurred to his mind that the disease was not lupus. As mentioned, he had had very considerable experience in treating skin diseases at one or two of our dispensaries. After hearing from him the history of the case, and the description of the lesion, I said that I should prefer to see the patient before advising the treatment.

On June 26th she came to my office, and her whole appearance was such as to lead me at once to suspect that she was the subject of inherited syphilis. She was twenty-three years of age, but was very much below the size which would be expected at that age; her form had none of the roundness belonging to it; nor was there any emaciation; she was simply undeveloped.

\*Read before the American Dermatological Association, September 6, 1877. For discussion thereon see Archives of Dermatology, January 1878, p. 70.

She had more the appearance of a girl from eleven to thirteen years of age instead of twenty-three, although intellectually she was quite equal to her years.

Her forehead was square, or rather prominent at the sides, and sunken in the middle. The teeth exhibited in a most markedly characteristic manner the peculiarities recognized as belonging to hereditary syphilis. The upper central incisors were notched, and greatly thickened. The other incisors were also mal-formed, and very small, and the canine teeth were curiously peg-shaped. The lower teeth were very small, not larger than those of a child eight years old. They stood separated, and were more or less irregularly placed.

Her history was : She had always been delicate. At four years of age she had an abscess under the right jaw. At five years she had severe spasms on three occasions, remaining several hours without speaking. Three years ago she was under the care of the late Dr. Althof, for double vision, at which time she suffered with the eyes for a year. Her mother, who is a very intelligent woman, said that the patient had never had any eruption on the skin but the present one, except a small spot on the inside of the right thigh, soon after birth. This may have been a mucous patch. She gives no other history of the earliest manifestations of the disease. The eruption for which she consulted me appeared first during the preceding September, nine months previously. She then noticed a small swelling on the anterior surface of the lower third of the right forearm. It was hard, and of a reddish color. She poulticed it ; it broke, discharged some, and has increased in size since, with the addition of new masses around it.

When first seen there was on the lower third of the right forearm an irregularly shaped mass of gummy induration, about three inches wide, and extending two-thirds of the way around the arm. It was perforated in many places by points of ulceration and sinuses, from which there appeared to be a moderate amount of discharge. At times the pain was very severe in it, so as to prevent sleep. She had been variously treated by a number of regular and irregular practitioners ever since its first appearance, but with no benefit ; but, on the contrary, with a constant increase in its size. The treatment had generally consisted in local applications.

On questioning the mother, I learned the following family history : She had been the subject of sixteen pregnancies. The first four resulted in healthy children, two of whom are living, and healthy, at thirty-eight and thirty-nine years of age. One died at thirty-one years, and a boy at eight months, from natural causes. The mother then contracted a venereal disease, and had an eruption on the buttocks. She then began to have miscarriages, and ten dead-born children followed each other, all at nearly or about full term, with one exception. She says that



they would appear to die *in utero* about six days before delivery, when she would feel a shivering sensation pass over her. Two years elapsed between the last still-birth and the birth of the present patient, who appeared healthy, with the exception mentioned, of a small eruption on the right thigh.

The points of interest in this case are: the length of time during which the eruption was unrecognized and untreated; the late period at which a skin lesion manifested itself for the first time, namely, at about twenty-two years of age; the absence of early eye troubles, for mother and daughter are very certain that no lesion of this organ occurred until that for which she consulted Dr. Althof three years ago: the kind of eye lesion, namely, double vision, a common one in acquired, but rather rare one in hereditary syphilis. It would be interesting and valuable to know at how late a period skin lesions have been observed in hereditary syphilis, either for the first time, or continued from earlier years.

She was placed upon bichloride of mercury and iodide of potassium in small quantities, and in less than two months the lesions had entirely disappeared.

The second case, which I wish to report, exhibits the long-continued eruption of hereditary syphilis up to an age greater than that in the preceding case.

CASE II.—Mrs. H., aged twenty-four, first came under my care, August, 1874. She is fairly developed, but bears on her face the marks of the depression caused by long sickness. When first seen there were the active elements of a tubercular eruption upon the forehead, right ear, arms, knee and back. On the left arm there were two patches, of a dull red color, about an inch and a half in diameter, composed of curved lines, or rows of tubercles, which have advanced, leaving scar tissue behind; which latter surrounded the elbow. The right arm was quite similarly affected. On the shoulders an eruption of the same character is seen, dark red, or copper colored, with some crusting in places, composed of irregular patches of tubercles, and cicatricial tissue by the side of the more recent disease. The eruption extends down the back six or eight inches. Near the left knee there is a patch of the same form of lesion, and a few scattered tubercles on the upper lip. All portions of the eruption present the same features, composed of tubercles of a dark red or coppery color, elevated from one to two lines above the surface, either touching each other, or separated by an erythematous redness. The cicatrices are all alike, supple, mostly white, the more recent ones stained, and slightly depressed.

In the middle of the forehead there is a depression in the bone, pyramidal in shape, the apex resting at the bridge of the nose, and being about two inches wide at the base. Of the origin of this she can give no exact account. It has taken place slowly, beginning, she thinks, at about sixteen years of age. There has never been any externally discharging ulceration there.

When five years old she had a deep sore near the ankle, which lasted four or five months, prevented her from walking, and which has left a scar. Two years afterwards, when she was seven years of age, the present eruption first made its appearance, and has continued since. She has been under medical treatment off and on, but never with any great success.

Her family history was not as clear as could be wished. She thought her father was healthy. A sister, thirty years of age, she said, had the same eruption; and her sister's children were also affected. She herself has been married seven years, and has had four children, two of which are dead.

There is, of course, a possibility in this last case that the syphilis may have been acquired during early childhood, before seven years of age, when the first eruption appeared, but the rarity of cases of acquired syphilis in such young subjects, and the course of the eruption, together with the loss of bone substance in the forehead, without external ulceration, point much rather to inherited disease. In this case the age of the skin lesion is interesting, lasting as it has since she was seven years old, and stands in striking contrast to that in the first case, where it appeared first when the patient was twenty-two years of age.

This patient made gain for a while under anti-syphilitic measures, several of the tubercles which were at first ulcerated healing completely, but she was lost sight of after six months observation, and the ultimate results cannot be stated. When last at the office she was improving, and as she was in moderate circumstances, she may have continued treatment with success, without further advice.

## MULTIPLE CHANCER OF THE NIPPLE.

BY E. L. KEYES, M. D.

**M**RS. X., 41 years old, was referred to me in November, 1877, by Dr. E. A. Banks, as a curious example of primary syphilis.

She has two healthy children, the youngest two years old. She nursed the latter during nineteen months. At this period a friend, whom she believed to be healthy, died in child-bed of her first baby. Mrs. X. weaned her own infant, and took the new one, when a few days old, to nurse it. When the new baby was two months old its mouth became sore, but its unsuspecting foster-mother continued to suckle it during one month, washing its mouth with borax, etc. Meantime the infant got the snuffles, excoriations appeared upon its anus, arms, lips, legs, fingers and scalp, and finally it was sent to an hospital, where it died, in what manner could not be ascertained. It was also impossible to learn anything positive about the child's father.

Shortly after the baby went away, about one month after the sores had first been seen in its mouth, a number of lumps appeared about the base of each nipple of its foster-mother. The nipples are not known to have been cracked or sore in any way previously.

When Mrs. X. visited me the lumps had existed about one month. At the base of each nipple the separate lesions stood out distinct, discrete, each raised prominently above the surface, and nearly uniform in size and appearance. There were eight, arranged in a semi-circle about the base of the right nipple; four similarly situated on the left side. In size each lump was a little larger than a split pea. They were flattened, livid at the base. The apices were dry and squamous, with the exception of one on the left breast, which was moist and oozing, whitened on top, a typical mucous patch of the skin. None of the lumps were indurated. They were entirely painless. In each axilla were two or three hard, enlarged glands, distinctly painful on pressure. No other lesions were present.

Mrs. X. was taken before the New York Dermatological Society, and a unanimous opinion was there entertained that the lesions were secondary in character—so much did they resemble mucous patches.

A careful examination of the anus and genitals, mouth, etc., was therefore instituted. These parts were found normal.

Three weeks later, seven weeks after the first appearance of the sores, the patient had a rise of 1° F. in temperature, began to feel ill, cervical adenopathy developed, osteocopic pains appeared, and the whole body became covered with a typical syphilitic roseola.

In this condition the patient was again presented to the Dermatological Society, after having been a short time under mercurial treatment. At this date the chancres were perfectly dry, and considerably flattened, but somewhat more indurated than when first observed. The axillary glands had become indolent, and were markedly indurated.

This case seems sufficiently irregular in the situation, number and appearance of the primary lesions to justify its record.

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#### NOTE ON POMPHOLYX.

BY A. R. ROBINSON, M. B., ETC.

IT is to be regretted that the discussion which was carried on through the columns of the *British Medical Journal*, and *Archives of Dermatology*, on this disease, and which was caused by the publication of my paper last year in the *Archives*, was so barren in scientific results, owing to the personal

and wandering nature of some of the articles. My paper was written with the sole object of assisting in the solution of the question of the nature of the disease. If some of the papers which were intended as a reply to my article had contained the results of positive microscopical, chemical, or clinical observations, and not assertions, there would no longer be that difference of opinion which still exists. I refer especially to Dr. Fox's papers, which contained nothing whatever that can be considered a positive contribution.

At present, the question seems to me to be narrowed down to two points. 1st. Was my case one of true "cheiro-pompholyx," or "dysidrosis?" 2d. If it was, were my observations and studies on its nature and pathological histology correct?

As regards the diagnosis, I have only to state that my patient was shown to several dermatologists, including Dr. Bulkley, of this city, and Dr. Duhring, of Philadelphia. Dr. Duhring saw the patient only once, but Dr. Bulkley has seen him several times, and both agree that the eruption in this case corresponds exactly with Mr. Hutchinson's description of "cheiro-pompholyx," and with what they have always regarded as the dysidrosis of Dr. Fox. They are not defenders of the sweat-duct theory, and the statement in Dr. Duhring's work was made on the authority of Dr. Fox, and not from any study of the disease by Dr. Duhring himself. It is possible however, that we are mistaken in our diagnosis, and therefore a positive contribution from Dr. Fox would be very acceptable, and would correct any error that I may have committed. I protest, however, strongly against Dr. Fox making a diagnosis for me, and calling my case one of pemphigus, a disease to which my case bore no resemblance whatever, and in this opinion all are agreed who have seen the case.

With reference to the second point, viz: were the conclusions which I drew from my studies of the disease correct, this can be answered only by microscopical study. I am at present engaged upon the work and if I can show that the previous observations were incorrect, I will not hesitate to correct myself. As far however, as my observations have gone, there seems to be no ground whatever for changing the views expressed last year.

As regards "dysidrosis" being an inflammation of the coil of the sweat apparatus, I might state that though I have seen numerous vesicles produced by an inflammation of the coil of the sweat duct, none of the vesicles were ever deep-seated or had a sago-grain appearance, all of them being seated in the corneous layer (microscopically examined).

As to the value in a controversial sense, of the kind of reaction of the contents of the vesicles, Dr. Fox has misquoted my remarks, a proceeding I consider unfair in an argument.

As regards his contradiction of my statement on hydroa, I refer the reader to that part of Dr. Fox's book on Diseases of the Skin, where he describes anomalous forms of bullous eruptions, as an

answer. I am, however, at present preparing a paper on pompholyx and some diseases of the sweat glands, in which I will discuss the whole subject, and endeavor to throw light on some obscure points; at the same time, in justice to myself, I will reply at length to the various papers which have appeared on "Dysidrosis," and defend myself from the imputation that I committed something ridiculous. This note is intended only for temporary service, and will not exclude future criticism of all points of the subject.

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## NOTE ON A HITHERTO UNDESCRIBED POINT IN THE DIAGNOSIS OF PSORIASIS.

BY L. DUNCAN BULKLEY, A.M., M.D.

After some considerable search, I fail to find mention of the point to which I desire to call attention, which, however, has been of constant service to me in demonstrating skin diseases to those attending my clinic for the past three years; if it has been noted in print, therefore, I am quite willing to withdraw any claims of priority, and only write now that this feature of the disease may be serviceable to others besides myself.

Most writers speak of the bleeding base beneath a patch of psoriasis, or rather the surface which is reddened and can be made to bleed easily after removing the pearly scales; the point to which I wish to call attention is the following:

After removing the pearly or silvery scales from a patch, by careful scraping, we come to a smooth surface which yields us no more scales, but which cannot be made to bleed by any pressure of the patch between the fingers sideways. But if, now, we carry the scraping, with a dermal curette, or a knife-blade further, with a gentle force, which is not sufficient to injure the healthy epidermis on each side of the patch, we will find that there is an even, membranous pellicle which slips off, not as a scale, but in a sheet, sometimes of nearly the actual size of the patch operated upon, leaving beneath it the red surface composed of the elongated papillæ and intermediate rete Malpighii, which may be made readily to bleed on very slight further scraping.

I do not find that this pellicular membrane exists beneath the patches of eczema, or squamous syphiloderm, or tinea circinata, and believe it to be often a valuable diagnostic mark of true psoriasis; it exists, as far as I have observed, even until quite healthy tissue has replaced the psoriatic patches.

## Clinical Reports.

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### *I. Unusual Skin Lesion in Hereditary Syphilis.* BY F. P. KINNICUTT, M. D., New York.

A. B., æt. 6 months. The father of the patient was under treatment for secondary symptoms at the time of his marriage, eighteen months ago. His wife, a healthy woman, became infected a few weeks after her marriage. A primary sore was followed by secondary symptoms, for which she was *not* treated.

An apparently healthy child, the patient, was born at full term. During the fourth week after its birth a polymorphous eruption was developed, with mucous patches in the mouth. The patient was subjected to regular treatment for several weeks. With the subsidence of the symptoms, the treatment was discontinued. Two months since the glands of the left side of the neck became swollen, suppuration occurring in one of them. A month later, the glands being still swollen, the corresponding side of the face began to swell, the swelling beginning in the vicinity of the affected glands, and quite rapidly extending into the cheek.

The patient was admitted to the out-patient department of the New York Hospital, on Feb. 15th, and the following notes of the examination were made :

The patient is a fairly well developed child, but anæmic. The sub-maxillary glands of the left side are swollen, a cicatrix existing at the site of a recent suppuration. There is a slight and uniform swelling, of irregular outline, extending upwards and forwards from the affected glands, and involving a greater portion of the cheek. The affected portion has a peculiar lardaceous look, with little, if any, appearance of congestion, and a slightly doughy feel. The swelling involves the entire structure of the skin, which is freely movable on the subjacent tissues. There is no evidence of an inflammation of the deeper lymphatic vessels about the periphery of the lesion. Specific treatment was ordered for the patient.

*Feb. 22d.* There is marked improvement, both as regards the

cutaneous lesion and the swelling of the glands. Treatment continued.

*March 14th.* There has been continuous and rapid improvement since the last note, and to-day *no trace* of the cutaneous affection can be discovered, the skin having regained its natural appearance and feel. The swelling of the glands has almost wholly disappeared. The treatment is to be continued.

REMARKS.—An angeioleucitis, *limited to the lymphatics of the skin*, the apparent reversal of the process which usually obtains in this affection, viz., an irritation conveyed *from* the glands to their afferent vessels; together with the presumably syphilitic nature of the affection, as shown by the history of the case, and the prompt subsidence of the symptoms under specific treatment, are points worthy of record and further study.

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## II. *Case of Iodic Purpura.* BY ROBERT ABBE, M.D., New York.

W. D., aged 30, England, in excellent general condition, presented himself with three deep tertiary ulcerations upon the anterior half of the tongue. He gives the history of having had primary and secondary syphilis about seven or eight years ago.

Six years ago he had swollen testicle, first on the right, then on the left side, which disappeared under the use of iodide of potassium, which did not then cause any eruption. A year and a half ago he had deep and painful ulcers of the back of the tongue which were cured by some medicine.

Four months ago, three ulcers came on the front portion of the tongue, which still remain; one the size of a pea, another the size of a three-cent piece, and another that of a penny. He was ordered at once,  $\mathcal{R}$  Potass. ioidid., gr. x., Hydrag. biniodid. gr.  $\frac{1}{16}$ . M. t. i. d.

The ulcers rapidly cicatrized, and were soon healed. After less than a fortnight's treatment an eruption of petechial spots appeared about the ankles and on the forearm above the wrists; those on the ankles were of deep purple color. There were not more than fifty or a hundred upon either ankle, while upon the forearms there were half that number. Upon stopping treatment as the tongue was cured, they disappeared. Shortly afterward, the medicine was again renewed and the eruption again appeared. It was continued only a few days when he seemed so well that no further observation was taken of the case until about three months after, Jan. 22, 1878, when the man presented himself with a very vivid and purpuric eruption of both legs and forearms, and with the following history:—Since he was last seen by me he had twice renewed the same medicine on account of not feeling particularly well, and after a few doses had both times had a vivid eruption appear as before; the time before the present one, he

had taken but *two* doses (=pot. iod. gr. xx.) before it appeared, but it had quickly gone away on stopping the medicine.

On the present occasion he had taken the medicine, not because he had occasion to, but he had been out of work and had nothing better to do. In two days the eruption was out in full force. It covered the entire anterior and posterior of the middle of the tibial region of the leg, and thinned out toward the knee and about the ankle; few spots appearing below this point. In parts the spots were discrete, but for a space the size of one's hand spread out they merged together, giving the skin a deep purple hue.

On either forearm were very numerous purpuric spots pretty uniform in size, and extending from wrist to elbow; but none above elbow, or knee. The skin was otherwise normal; no elevation of temperature. There were no traces of *scorbutic* tendency; the gums were normal, and his general appearance was excellent. The patient had become alarmed, but was assured that all would disappear on stopping the medicine; and so it did with remarkable quickness, for in two weeks time not even the staining could be discovered.

P. S.—*March 13.* After taking three doses of the pot. iod. mixt. at my request, the purpuric eruption has again come out to-day, quite vividly on the legs and forearms. This is the sixth appearance of the eruption following the iodide. The fifth and sixth outbreaks of purpura were accompanied by sharp epistaxis.



## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

REPORTED BY DR. P. A. MORROW, SECRETARY.

*Eighty-ninth Regular Meeting, January 8th, 1878.*

DR. F. P. FOSTER, PRESIDENT, IN THE CHAIR.

DR. PIFFARD presented a case of *dysidrosis*.

DR. MORROW exhibited a case of

#### Lichen planus,

in a woman æt. 35. Patient gave following history: General health, excellent. First noticed the appearance of the disease in August last, in the form of small, red pimples upon the legs, which she supposed to be flea bites. It soon extended over the legs and feet, with a few scattering papules on abdomen and back of thighs. In October, three months ago, noticed same eruption on back of hands and wrists, which now extends above elbows. The eruption is symmetrically developed, and the papules are very characteristic of the miliary form.

DR. MORROW presented a case of *tubercular syphilide*, involving hairy scalp, entire forehead, and large portion of face and neck.

DR. KEYES brought before the society the case of

#### Multiple chancre of the nipples,\*

which had been exhibited at the previous meeting. At that time, on account of the number of chancres, and their strong resemblances to mucous patches, the opinion was expressed by several members of the Society that they could not constitute the initial lesion, but belonged to the secondary manifestations. All doubt upon this point had been set at rest by the subsequent history of the case. Seven weeks after the first appearance of the sores upon the breast, a roseola declared itself, and other secondary manifestations have followed in regular order.

DR. PIFFARD brought before the society a young woman suffering from a peculiar form of skin disease, which he was

\*For description of case see page 126.

unable to class. The case was presented to the society for diagnosis.

DR. KEYES presented the case of

### **Acute eczema,**

which he had brought before the society at the October meeting. The patient exhibited a marked improvement.

In the discussion of Dr. Piffard's case,

DR. WEISSE thought it unquestionably one of dysidrosis.

DR. FOSTER remarked, that while the present aspect of the case seemed to justify the diagnosis of dysidrosis, yet the patient's account of the first appearance of the disease, in the form of minute, red points, would seem to militate against this view of its nature.

In the discussion of Dr. Morrow's case of lichen planus,

DR. FOX remarked that it offered an admirable opportunity of noting the distinction between the miliary and lenticular form of papules. In this case the miliary type was most exquisitely displayed.

In the discussion of Dr. Morrow's case of tubercular syphilide,

DR. TAYLOR remarked that the extent of surface involved, was not so unusually large. He had encountered other cases in which the lesion was quite as extensive.

DR. KEYES thought the greenish, crustaceous aspect of the lesion was quite typical and characteristic.

DR. ROBINSON thought Dr. Piffard's second case one of papular eczema.

DR. KEYES regarded its appearance as suspicious, and would prefer not to pass an opinion until the genitals were examined.

In the discussion of Dr. Keyes' case of acute eczema, Dr. Weisse wished to know what plan of treatment Dr. Keyes had followed?

DR. KEYES, in response, said that he had at first used tarry preparations, locally, and kept the affected surfaces covered with oiled silk and impervious dressings; internally, cod-liver oil. He had also given arsenite of soda for a while. This was attended with most satisfactory results. For the past six weeks the patient had taken cod-liver oil only, and used tar soap.

DR. WEISSE said that he was accustomed to use rubber or oil-silk dressing in all severe cases of eczema. He had also found that great relief was obtained from hot water applications. He was a strong advocate for baths in this and other forms of skin disease.

DR. PIFFARD called attention to the change which had taken place in the patient's hair since her first appearance. The hairy scalp was then covered with a recent growth of soft, fine hair. It was now coarser, darker in appearance, and had entirely lost its lanugo-like feel. He wished to know whether the original growth had altered in character, or whether it had fallen out, and been replaced by the present growth.

DR. KEYES was unable to say positively, but thought that the original growth had changed to its present appearance.

DR. WEISSE had seen patches of dark hair, which had changed to white in color. This change had taken place *in situ*.

DR. FOX related a case of alopecia, where the hair, previous to its falling out, had been light in color. A new growth afterwards succeeded, which was dark and luxuriant, and entirely changed in color.

DR. PIFFARD wished to know whether any member of the society had ever encountered a case of sudden blanching of the hair.

DR. KEYES said that he had seen a case of blanching of the hair, in which the bleaching process had taken place within a week.

DR. BRONSON stated that Dr. Brown-Sequard reports a case, which came under his personal observation, where bleaching took place in a single night.

DR. SATTERLEE reported a case of sudden blanching. The lady, a relative of his, who had black hair when she retired at night, found the next morning that it had turned almost entirely gray.

DR. FOX read the paper of the evening, on the

### **So-called pigmentary syphilide,**

in which he took ground in opposition to the views of Hardy and Fournier, that this lesion is in no proper sense a manifestation of syphilis. Instead of being a pigmentary formation, like chloasma, he thought that its essential characteristic was a loss of normal pigmentation, such as is met with in vitiligo. In fact, he regarded it as essentially a vitiligo, and its appearance in syphilitic subjects merely a co-incidence. His view of its non-syphilitic character was supported by the fact that it was uninfluenced by specific treatment.

DR. TAYLOR said that he entirely agreed with Dr. Fox in his view of the nature of the pigmentary syphilide. He had seen it upon the necks of women who had syphilis, and also upon one male patient. He had enquired whether there had been pre-existing lesions upon the spots occupied by these pigmentations, and the answer was invariably negative. The amount of surface involved in the pigmentation was entirely disproportionate to the size of the syphilitic lesions, and therefore could not be the result of the syphilitic lesions. In the case of an Austrian, who had been under his observation at the New York dispensary, the skin was abnormally dark. He had a roseola, which left whitish spots all over the body, giving the skin a mottled appearance. Each spot of pigmented skin corresponded to a spot of roseola. No increase of pigmentation occurred in the margin, as is usually seen in vitiligo.

DR. ROBINSON thought the pigmentation due to changes which

took place in the circulation. He had seen patches of white tissue after psoriasis.

DR. SHERWELL had never recognized the pigmentary syphilide, but was disposed to look upon its occurrence in a syphilitic subject as a co-incidence merely.

DR. PIFFARD remarked that the elements which enter into the production of pigmentation ought to be settled. Melanin, the normal coloring matter of the choroid membrane, which is different from the coloring matter of the blood, constitutes the pigment of the skin. In hyperæmia there is an exudation of red corpuscles. The coloring matter of these—hemato globulin—becomes transformed into granular hematin, which is precipitated. It would seem that there is an abnormal quantity of melanin deposited in the surrounding margins of vitiligo. The chemical differences between hematin and melanin should be considered in determining their relations to the productions of these and other pigmentations.

DR. WEISSE said that he had seen a beautiful case of pigmentary syphilide in Hardy's ward, at the St. Louis hospital, but had never encountered it in his own practice.

DR. BULKLEY had never seen a case of pigmentary syphilide. He had often seen pigmentations, resulting from skin lesions, but did not recognize them as pigmentary syphilide.

DR. FOSTER wished to know whether the vitiliginous patches were the sequelæ of syphilis, or whether they had not been remarked in other cases where there was no specific taint. This would settle the question as to whether their causation were due to syphilis alone.

DR. FOX said that the same appearance had been noticed in other cases.

The society then went into executive session.

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*Ninetieth Regular Meeting, January 29th, 1878.*

DR. SHERWELL presented a case of *ichthyosis*.

DR. MORROW presented a case of *erythema papulatum*.

DR. FOSTER presented a case of *lupus vulgaris*.

DR. FOX presented a case of *linear atrophy of the skin*, occurring upon the abdomen, and over the anterior aspects of the upper portions of the thighs.

DR. FOX, on behalf of Dr. Sturgis, presented a case of *psoriasis guttata*.

DR. PIFFARD brought before the society a case for diagnosis.

In the discussion of Dr. Sherwell's case of

### **Ichthyosis,**

DR. TAYLOR called attention to the fact that the integument of the flexor surfaces of the elbows, knees and groin was not involved by the disease. This striking difference between the outer sur-

faces of the joints and the flexures he had frequently noticed in mild cases of ichthyosis. He wished to know in what proportion of cases other members had noticed this exemption of the flexor surfaces.

DR. BULKLEY thought the proportion was very large. He could recall six or eight cases, in which there was a complete exemption of the flexures.

DR. PIFFARD called attention to the remarkable diminution of sweat glands, which was apparent under close observation. In these cases jaborandi would produce a free sweating, notwithstanding the diminished number of sweat glands.

DR. BULKLEY remarked that he had used jaborandi in one or two cases; that it had produced nausea.

In the discussion of Dr. Foster's case,

DR. BULKLEY said that he did not recognize it as lupus, but rather as epitheliomatous in character. The pathological changes, such as reddish tubercles, infiltration, scales attached at one edge, etc., by which he was accustomed to recognize lupus clinically, were certainly not present in this case.

In the discussion of Dr. Fox's case, DR. PIFFARD thought the condition might not be due to obesity, although the patient had at one time been very stout. In idiopathic atrophy of the skin the pathological changes commenced as neoplasms, which, by interstitial atrophy, produced this striated appearance. Dr. Damon first described and called attention to this fact.

DR. FOX said that the disease in this case first made its appearance as long welts upon the skin. Notwithstanding it occurred after obesity, this might be a co-incidence. He was strongly inclined to regard it as of idiopathic occurrence.

DR. BULKLEY remarked, in the discussion of Dr. Sturgis' case, that it was undoubtedly psoriasis. Its absence from the extensor surfaces was not significant; the importance of this, in a diagnostic point of view, had been very much overrated. This form, the guttate, was specially noted for its tendency to diffuse itself generally.

DR. SHERWELL read the paper of the evening, upon a

### **A substitute for cod-liver oil in cases of skin disease, attended with marasmus.**

After relating the circumstances which led him to employ oil of linseed instead of cod-liver oil, the doctor stated that latterly he was accustomed to use, in the place of the emulsified oil, simply the flax-seed itself. His patients were directed to carry it around with them, and take from a teaspoonful to a tablespoonful at a time. In this way they used sometimes half a cupful in the day. It was palatable and agreeable, and seemed to be readily assimilable. Its use was unattended with diarrhœa, and produced no eructations, or other disagreeable symptoms. He had used it in pemphigus foliaceus, lichen planus, lichen ruber exudativus,

psoriasis, and in many phthisical and diathetic disorders, with the happiest results.

In the recital of clinical histories, Dr. Foster gave a detailed account of the previous treatment of the case of general eczema, brought before the society by Dr. Keyes.

DR. PIFFARD donated a brochure "On Certain Points relating to the Nature and Treatment of Lupus," by Dr. H. G. Piffard.

The society then went into executive session. The report of the Committee on Revision of Minutes was read and received.

## Digest of Literature.

### I.

## DISEASES OF THE SKIN.

### ETIOLOGY, THERAPEUTICS, GENERAL TOPICS.

EDWARD B. BRONSON, M. D.

**Tuberculous ulceration of the skin.** CHIARI records a case of cutaneous ulcerations occurring upon the lower lip and about the anus, which was attributed to a deposit of tubercle in the skin. The subject was a man 32 years of age, who was affected with pulmonary tuberculosis and whose right lower extremity had been amputated in consequence of a tumor albus of the knee. It was during the healing of the amputation-wound that the ulcers made their appearance. Death from marasmus followed six weeks after the operation.

The ulcer on the lip occupied the greater portion of its left half, was of an oval form, 27 mm. wide, 14 mm. long, and 4 mm. deep. The edges were irregular, not markedly elevated, but moderately hard. The ulcerating surface was uneven, of a deep red color, with little yellow spots scattered over it. The secretion was thin and scanty. Microscopic examination showed infiltration of the tissues beneath and about the ulcer with numerous round cells, interspersed here and there with round nodules which varied in size from 0.1 mm. to 0.5 mm. in diameter. Some of these nodules were superficial and corresponded to the small yellow spots on the surface of the sore. The nodules were composed of small roundish cells which were closely clustered together and partly imbedded in a fine meshwork. To accommodate the nodules, the fibres of the original tissues had been forced assunder. The majority of the cells had already collapsed. They showed no nuclei. The epidermis about the ulcer presented no alterations whatever. About the anus were four ulcers of a character precisely analagous to the above.

The case is esteemed of considerable interest since tuberculous ulceration of the skin is certainly of rare occurrence, and indeed, not very generally admitted. Rokitsky and Lebert recognize only ulceration of the skin following softening of tubercle in lymphatic glands and bones that lie near the surface. Förster and Klebs, even claim an immunity for the skin from the miliary tubercles. On the other hand, Wagner and O. Weber admit a tuberculous ulceration of the skin, and the disease is especially described by Cornil and Ranvier. Others also have noticed it. *Med. Jahrbücher*, 1877, 3 *Heft*. p. 328.

**A case of undescribed eruption.** DR. BARLOW presented the following case before the London Clinical Society: The patient was a child two years old, and had been under observation for one year. The eruption first appeared when the child was about four months old, as circular, brown patches on the chest; they increased in size until the child was a year old, since when they had remained stationary. They appeared in the form of pigmental patches over the front and back of the chest and abdomen, and over the front and back of the arms, forearms, thighs and legs; they were very slightly raised; varied in size from the area of a split pea to that of a shilling (English), and were of a uniform olive-brown color. The face, hands and feet were free, and the child had not had jaundice. Scratching the skin brought out well marked wheals which suggested an urticaria perstans. Other eruptions appeared in this child. On the back of the neck, on one ear and on the chin an impetiginous rash had formed and scabbed over. Beneath the scabs deep ulceration had occurred, leaving punched-out looking sores, with very little suppuration and for some time no attempt at granulation. The floor of the ulcers was covered with a thin, serous discharge. Ultimately the sores healed with considerable loss of substance. The cicatricial tissue at the back of the neck now manifested a slight tendency to out-grow the level of the surrounding skin. The patient was apparently tuberculous, and the writer suggests that the ulcerations may have been of a strumous nature, and what would be described by Hardy as a scrofulide. *British Med. Journal*, p. 745, *June* 16, 1877.

**Diseases of the skin difficult to classify.** Among the incidents of a long practice DEVERGIE recalls some very curious cases of skin disease. They are described in a recent number of the *Annales de Dermatologie*. They were all cases very difficult to diagnosticate. One or two of them were studied with Alibert. Though all of them occurred in persons born and resident in France, the writer seeks to trace an analogy or relationship between them and certain described forms of disease indiginous in other countries. In several of them he discovered points of similitude with elephantiasis Græcorum, or liontiasis, as he prefers calling it; in one instance the disease is compared with frambœsia.



Much space is devoted to the description of a case of stigmatism which the writer had an opportunity for observing; in many particulars it resembled the famous one of Louise Lateau. With regard to the nature or relations of this extraordinary case we are left quite in the dark.

It would be impossible to epitomize the long article here but a perusal of it is especially commended to lovers of the curious. *Annales de Dermat. et de Syph.* No. 2, p. 110, 1876—77.

**Greenough on frequent forms of skin disease.** A series of articles was begun during the past year by DR. GREENOUGH which took the form of a treatise on the more common forms of cutaneous disease. But after running through four numbers of the *Boston Med. and Surg. Journal* the work was suddenly discontinued. The articles were of an elementary, practical character and contain considerable useful information. *Bost. Med. and Surg. Jour.*, Feb. 22, March 8, April 12, and June 21, 1877.

**Hebra on the continuous bath.** The practice of treating patients *under water* has been pursued for a number of years in the Department for Skin Diseases of the Vienna General Hospital with no inconsiderable measure of success. The practice was commenced by Hebra some sixteen years ago, since when over 500 cases have been treated in this way. The results are summarized in a series of articles by the younger HEBRA, with statistics based upon 203 recorded cases. In the remainder of the cases the histories were not accessible. The first important fact established by these cases was that certain dangers hitherto apprehended from prolonged bathing, or from the bath employed at supposed improper times, such as after eating, during menstruation, etc., had either been exaggerated, or, at least, did not exist where the bath was continuous. It was found that patients remained with their bodies immersed in water for days, weeks, and even months, eating, sleeping and performing every natural function as well as in their native element. And, furthermore, in those cases for which the treatment was employed there often appeared to be gained a very great alleviation of distress and a speedier recovery than could have been otherwise attained.

The apparatus for the continuous bath consists of a large rectangular box, in which a properly fitted iron frame-work is suspended, which, when spread with blankets, serves as the bed. That part of the frame where the head comes can be raised or lowered as desired by means of hinges. The box is then partly filled with water of the proper temperature, and the patient being placed upon the frame or bed, is lowered until all but the head is submerged.

During the first four or five days no change whatever is noticed except from the maceration of the epidermis upon the fingers and toes. After this it is very common for the patient to complain of pain in the soles of the feet, especially if he has corns.

This can be relieved by placing a hair pillow at the feet or by resting the feet upon cushions so as to raise them above the surface of the water for a time. In persons with tender skins a papular eczema is apt to break out in from eight to fourteen days, with pretty lively itching. This is treated by rubbing the parts with oleum rusci, the patient remaining in the water. Beyond these symptoms no bad effects whatever were observed.

Of the diseases thus treated the most important were burns of various degrees of severity; pemphigus, the most marked benefit being observed in the foliaceous variety; variola confluens; gangrenous buboes; phagadænic chancres; syphilitic ulcers; and phlegmon with gangrene of the skin and subcutaneous cellular tissues. *Wien. Med. Wochensch.*, Nos. 36, 37, 38, 39, 1877.

**Iodoform in skin diseases.** LAILLER regards the action of iodoform, when applied topically as of a dual nature, comprising an anæsthetic and a cicatrizing action. Upon the former, he maintains, depends the success of the remedy in various painful affections, such as fissures of the anus, hemorrhoids, ulcerations of the throat and ulcerating cancer of the face, throat or womb. The healing property of the drug is supposed to be largely dependent upon the iodine in its composition. With this theory in mind, a substitute for iodoform was sought in an ointment of iodine, which it was hoped would prove equally efficacious while avoiding the unpleasant odor of the other. This hope, however, was not realized. No means of combating the penetrating odor of iodoform are suggested by the writer. The mixture of tannin with the drug for this purpose has been elsewhere proposed and proves fairly successful. For application to deeply-seated organs, as the uterus, the throat, etc., a solution in ether is recommended to be used in an atomizer. By this means the diseased surface is coated with a thin layer of iodoform in the finest state of subdivision, and thus a less quantity of the remedy will be required. *La France Méd.* p. 665, Oct. 29, 1877.

While Lailler considers only the topical use of iodoform and regards its internal administration as valueless, BERKLEY HILL claims to have obtained from its internal use some very good results. He believes that it acts more rapidly than the iodides and is more readily borne than they. He gives it in pills with extract of gentian, each pill containing a grain and a half of iodoform. He begins with one three times a day, and gradually increases the dose until eight or ten are taken in the twenty-four hours. Especially good results have been obtained, he claims, in certain syphilitic ulcerations of the tongue, accompanied with thickening of the epithelium tending to the production of fissures, which are apt to be very rebellious to ordinary methods of treatment. He also finds it serviceable in various gummous affections, as well as in syphilitic cranial or pericranial disease attended with severe headache. *British Med. Journal*, p. 127, Jan. 26, 1878.

**Chrysophanic acid in skin diseases.** BALMANNO SQUIRE, in a note to the *British Medical Journal*, reiterates his faith in the efficacy of chrysophanic acid both in parasitic and non-parasitic diseases, but especially in the latter. He speaks of goa powder as simply dirty chrysophanic acid. He does not regard the staining of the finger-nails and clothing by the acid as a measurable disadvantage, in view of its great beneficial effect upon the skin.

There are two other notes relating to chrysophanic acid in the same number of the journal, by two practitioners (Thorpe and Ollerhead), who have made trials of the remedy. While these commend its virtues in the treatment of psoriasis, rather greater importance than by Squire is attached to the red staining which the acid causes. It is observed that the hairs also will be stained by it as well as the finger-nails if the remedy be applied to the scalp. In one instance where an ointment of the acid was applied over a considerable surface of the body, impairment of vision was complained of. *British Med. Journal*, May 5, 1877.

**A new remedy.** The Tong Pang Chong is the name of a plant used by the natives of the Malay Peninsula for the treatment of certain diseases of the skin. DR. MURRAY communicates the results of some experiments with it to the *British Medical Journal*. He finds it remarkably efficacious in ring-worm and certain allied diseases. He regards it as superior to goa powder. A fluid extract from the root of the plant was used, the method being to paint the affected parts with it by means of a brush at night before going to bed. A crystalline substance enters into its composition which the writer surmises is chrysophanic acid, to which, therefore, its good effects may be due. *Brit. Med. Journ.*, May 19, 1877.

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## DISEASES OF THE GLANDS.

ROBERT CAMPBELL, M. D.

**Acne rosacea treated with chrysophanic acid.** BALMANNO SQUIRE reports a case of acne rosacea, occurring on a lady, 45 years of age, who had had the affection one year and a half, which was cured by the application of chrysophanic acid ointment. Twenty grains of the acid was dissolved in one ounce of lard, at the temperature of an oil bath; this was rubbed into the face, except the lips and eyelids, three times a day. During the last ten days of treatment the ointment consisted of forty grains of the acid to one ounce of lard. The patient was under treatment from Jan. 19th to Feb. 27th, when the eruption had entirely disappeared. The application of the ointment caused no smarting and only slight staining of the surface, which passed away in a few days after discontinuing its use. There was a little puffiness of the face to be seen. Internally glycerole of the nitrate of bismuth containing four grains to each dose, was given three times a day, for a few days, but without producing any effect. *Medical Times and Gazette*, p. 665, June 23, 1877.

**Pathological anatomy of molluscum contagiosum or acne varioliformis.** VIDAL communicated to the Société de Biologie the result of his investigations in reference to the pathological anatomy of acne varioliformis, or molluscum contagiosum. He says, that it is an affection of the sebaceous glands having its origin in the centre of each of them; the whole gland is hypertrophied, and, the most characteristic lesion is a colloid degeneration of the cells. He has attempted to inoculate but without success. Renault believes the disease to be a corneal degeneration. Vidal says that it cannot be a corneal degeneration, because in coloring a preparation with aniline blue, and then with picric acid, the corneal cells of the epidermis are tinted blue, whilst the masses

arising from cellular degeneration and acne varioliformis are turned green in color. Acetic acid, which attacks the corneal cells, is without action in this disease. *Le Progrès Méd.* p. 450, June 9, and p. 489, June 23, 1877.

**Molluscum contagiosum.** KAPOSI arrives at the following conclusions in reference to molluscum contagiosum. 1. The contagiousness of the so-called molluscum contagiosum has not yet been proved, and he does not believe that it exists. The name should be stricken from nomenclature. 2. The so-called molluscum contagiosum of Bateman, and that of recent writers, belong to the sebaceous system, and are equivalent anatomically; that of Bateman belonging to the sebaceous gland, the other form to the common opening of the sebaceous and lanugo hair follicle in the beginning, and later to the gland lobules also. He, therefore, for the latter reason, suggests that the name molluscum sebaceum, adopted by Hebra, should be employed in designating both forms. 3. He also says, that although both forms often occur together, still they may preponderate, or exist exclusively, in one or other form, so that he prefers to call that of Bateman molluscum attheromatousum, and the pock, or wart-like form, molluscum verrucosum. He regards the peculiar, large bodies found within them as epidermal cells with modified protoplasm, and states that the same cells are found in other growths. *Vierteljahr. für Derm. u. Syph.*, iv *Fahrg.* 3 *Heft.* *Boston Med. and Surg. Four.* p. 651, Dec. 6, 1877.

**Molluscum contagiosum.** SIMON believes molluscum contagiosum is in no way connected with the cutaneous glands and hair follicles, but that it is an hyperplasy of the rete mucosum. He also finds that the so-called condyloma subcutaneum is identical in structure with molluscum contagiosum, containing the same, characteristic bodies, and he suggests for both of them, the term epithelioma molluscum, a name introduced by Virchow. *Viertelj. f. Derm. u. Syph.*, iii *Fahr.*, 3 *Heft.* *Boston Med. and Surg. Four.* p. 679, June 7, 1878.

**Malarial unilateral hyperidrosis.** GAARDER reports a case of hyperidrosis, affecting the right arm only, which was marked by a periodical remission. At night there would be a remission, in the forenoon the main symptom was a tingling sensation in the limb, and in the afternoon the sweating was most marked. The treatment was quinine, in pill form, two grains every hour. On the third day after commencement of the treatment, the hyperidrosis had ceased. *St. Louis Clinical Record*, p. 226, Dec. 1877.

**Notes on anhidrotics.** HAYDEN has obtained good results from the use of the "liquor" found in tan-yards, which is a strong solution of oak-bark, in sweating of the hands, feet and axillæ, occurring in people in good health otherwise. He also says that he has no doubt that electricity may be found to be more potent

than medicines in hidrosis. In the discussion, which followed the reading of the paper, Dr. Finny said that he had used atropia with great success and found that the solid form was more efficacious than the liquid. *Transac. of the Medical Society of the College of Physicians. Dublin Jour. of Med. Science, p. 358, April 1877.* †

**Phosphorescent sweat.** PANCERI mentions the case of a Neapolitan physician, who had eaten of fish and afterwards experienced malaise and nausea and the phenomenon of a luminous sweat. P. attributed the phosphorescence of the sweat to the elimination of the fatty matter of a fish, the *pesce baidiera*, upon which the physician was making observations. Other similar cases of luminous sweating are mentioned. *Cincinnati Lancet and Observer p. 504, May 1877.* †

**Researches on the modifications of the secretion of sweat in disease of the skin.** AUBERT in making experiments, on the secretion of sweat, found that when the skin was irritated, there was a complete suppression of sweat from the glands, which lasted sometime after the irritating cause was removed. In the tissue of a cicatrix a great many of the sweat glands are destroyed, but those which remain secrete an increased quantity of sweat. *Le Progrès Méd. p. 676, Sept. 1, 1877.*

**A case of chromidrosis.** DELTHIL reports a case of chromidrosis occurring in a girl sixteen and a half years old. Around both orbits and on various parts of the body were discolorations of a blackish-blue hue, which stained the clothing and were evidently the product of a natural secretion. The appearance of this secretion was intermittent and did not correspond with the catamenial epoch. A peculiar phenomenon presented itself, viz: the falling off of the nails, all those of the right foot were already gone, while those of both hands and the other foot were tender and appeared as if about to fall off. The patient menstruated regularly, and was in good health with the exception of a slight nasal catarrh. Some spots of purpura were to be seen at times. The gums were painful, bled easily, and were spongy. The girl had had urticaria and measles, but she presented, more especially, some of the phenomena of hystero-epilepsy in which the crises sometimes lasted for two days. These crises were accompanied by a peculiar form of hyperesthesia, so that the hairs appeared as rigid as those of an electrified animal and the single touching of the hair follicles provoked an erethism with hystero-epileptiform convulsions. In conclusion, Delthil asks if chromidrosis is a true morbid entity, if the phenomena described have not an analogy to scorbutus, ergotism, and different other affections characterized by an alteration in the function of the vaso-motor nervous system. *La France Méd., p. 186, March 24, 1877.* †

**Fetid feet.** RUMBOLD recommends bathing the feet in hot water for profuse sweating. His plan is to keep the feet in warm

water for fifteen minutes, before going to bed, keeping the water warm by adding boiling water at intervals. After drying the feet thoroughly, the following ointment is made use of:  $\mathcal{R}$ . Acidi Salicylici, Potass. Bromid *aa* gr. v; Vaseline  $\mathfrak{z}$  i. M. To be rubbed in with considerable friction. Solution of hydrate of chloral one part in one hundred has been recommended. Burton uses permanganate of potassa, three parts in one thousand of water. *Chicago Med. Journal and Examiner*, p. 444 Oct. 1877.

**Sulphuric acid in bromidrosis.** TAYLOR gives sulphuric acid in bromidrosis of the feet, and has met with success. The dose to be given should be sufficient to make half a glass of sweetened water taste quite tart; this he gives morning and evening on an empty stomach; in a few days the acid should be discontinued two or three days, and then recommenced. In addition, ferri et potassæ tart. gr. v—vii in sherry wine should be given after dinner. *Chicago Med. Journal and Examiner*, p. 412, May 1877.

**Sudoriparous adenoma of the hairy scalp.** PINGAUD reports a case of adenomatous tumor which he removed from the scalp of a patient. It was situated near the vertex, about the size of a large pea, was slightly flattened, with a surface entirely smooth, white and polished, and did not present a depressed, or blackish point corresponding to the orifice of an obliterated gland. When pressed it gave to the fingers the sensation of a small elastic fibromatous mass half encased in the skin, like an egg in an egg cup. On cutting the tumor in two, it was found to consist of dense tissue, whitish, like lard; the superior surface was continuous, without any line of demarcation, into the healthy skin, which appeared atrophied. The fibromatous nature of the tumor appeared evident.

The tumor having been hardened in alcohol and picric acid—forty-eight hours in each—was submitted to a microscopic examination. The skin, which covered the tumor, was found intact, being separated from the neoplasm by a layer of connective normal tissue, prolongations extended into the deeper surrounding parts. The tumor under a low magnifying power appeared lobulated, like a gland. Each lobule presented, on section, a fibrous stroma rather abundant and composed of connective tissue having a normal aspect. The stroma included in its meshes prolongations which communicated among themselves and were filled up with cells having a rounded orifice in the centre, at certain points the tumor had the appearance of tubular epithelioma, but its lobular disposition, its well defined border and the existence of round orifices in the centre of a number of meshes led Pingaud to believe that it was an adenoma of the sudoriparous glands. *Le Progrès Méd.*, p. 623, Aug. 11, 1877.

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## INFLAMMATIONS; CHRONIC, SQUAMOUS, PRURIGINOUS AND PUSTULAR.

GEO. HENRY FOX, M. D.

**Treatment of psoriasis inveterata by jaborandi.** PROF. THIRY reports the successful treatment of two cases of psoriasis by an infusion of jaborandi, given in one case in doses of four grams, and in another case three to seven grams (3 i—3 ij), given at intervals of three or four days, for about six weeks. Cramps in the stomach were caused by the remedy. *La Presse Méd Belge*.

**Psoriasis treated by chrysophanic acid.** DR. J. C. O. WILL reports an aggravated case of psoriasis successfully treated by chrysophanic acid ointment (15 grains to an ounce of hot lard). He thinks highly of Fowler's solution, given in large doses (30 minims three times daily, if necessary), but welcomes the introduction of this new and promising remedial agent. He mentions its disadvantage of indelibly staining the clothing, and cautions against allowing it to come in contact with the eyes, as it may give rise to intense irritation, accompanied by marked dilatation of the pupil. *Med. Press. and Circ.*, Aug. 8, 1877.

**Chrysophanic acid in the treatment of skin disease.** SQUIRE, B.; THORP, O. W.; OLLERHEAD, T. J. Squire, whose experience is not limited to a single case, recommends the local use of chrysophanic acid (the active principle of goa powder), in psoriasis, but adds, "It is fair to say that the remedy does not invariably succeed. In some cases it fails altogether, even after a fair trial." To Squire we owe the suggestion of treating psoriasis by a closely fitting dress of india rubber, which has proved to be an excellent, though by no means an infallible mode of treatment. It would be interesting to hear Dr. Squire's opinion

as to the comparative merits of these two modes of treatment, each of which he has thoroughly tested. Possibly he might state the indications for the use of one, in preference to the other. Squire, Thorp and Ollerhead all allude to the staining which is caused both by chrysophanic acid and goa powder. The hair and nails, as well as the clothing, become dyed of a dark purplish hue. *Brit. Med. Jour.*, May 5, 1877.

**Two cases in illustration of the efficacy of chrysophanic acid, in the treatment of psoriasis, after failure of various other remedies.** The pith of what WHIPHAM has to offer is contained in the title of his article, which would be more interesting if it were shorter, and based upon the treatment of more cases. *Med Times and Gaz.*, Sept. 22, 1877.

**Psoriasis treated with phosphorus, "perles" and chrysophanic acid.** SQUIRE compares a case treated by him with a case treated by Whipham (*Med. Times*, Sept. 22, 1877), in both of which phosphorus produced a good effect at the outset, and chrysophanic acid ointment cured the disease entirely. Squire concludes that after about a month's use of the former remedy, the antagonism of the phosphorus to psoriasis finds its equilibrium, a limit falling short of the complete cure of the disease.

If increased gradually, the dose may begin with one-thirtieth grain, and reach one-eighth grain of phosphorus, three times daily. *Brit. Med. Jour.*, Nov. 3d, 1877.

**Treatment of psoriasis by goa powder.** A. D. KEITH reports a single case, in which goa powder, rubbed up with lard (gr. 90— $\frac{3}{4}$  j), cured in ten days a case of extensive psoriasis, in which all the known remedies, including a close fitting dress of india rubber, had been employed, without the slightest benefit. *Brit. Med. Jour.*, April 28, 1877.

**Arsenic in psoriasis.** LAILLER thinks that arsenic is of but little value in the treatment of psoriasis, and relies mostly upon external remedies, especially frictions with the oleum cadini. *La France Méd.*, Sept. 5, 1877.

**On the etiology of psoriasis.** WUTZDORFF, in a lengthy article, endeavors to prove that psoriasis is not dependent upon any dyscrasia, but results from a tendency of the skin to develop scaly patches when subjected to external irritation, of either mechanical, chemical or thermic nature. This tendency is hereditary, and is never acquired. *Viertelj. f. Derm & Syph.*, 1877, Heft I. and II., p. 203.

**Cutaneous psoriasis and its transformation into epithelioma.** M. TILLAUX read a paper before the Société de Chirurgie, on the transformation of cutaneous psoriasis into epithelioma. In a case cited, a large epitheliomatous mass was

removed from the back, where eleven years before there had been an isolated patch of psoriasis. M. Trelat remarked that the case showed that cancer might develop upon any irritated portion of the skin or mucous membrane. *La France Méd.*, May 26, 1877, p. 333.

**Pityriasis rubra universalis.** In connection with a case of pityriasis rubra, reported by Hebra, Jr., in which the autopsy revealed walnut-sized tubercular nodules in the cerebellum, LUDWIG FLEISCHMAN calls attention to a progressive atrophy, with desquamation of the skin, in children, which he has described as resulting from tubercles in the brain, and consequent affection of the trophic cutaneous nerves. As the disease in the case referred to began in infancy, he thinks it probable that the nodules were developed at that time, and regards the skin lesion as due to the cerebral condition. He recommends a careful microscopic examination of the trophic nerve centres in all fatal cases of this affection. *Vierteljahrsschrift für Derm. u. Syph.*, 1877, I. and II., Heft.

**Notes on the successful treatment of three cases of pityriasis rubra.** We find in this article, by R. K. HINTON, a proof of the deplorable state of dermatological nomenclature. Three cases, which might have been the pityriasis rubra described by Bateman fifty years ago, are reported as successfully treated, and the reader is led to believe that these cases were instances of that rare and interesting form of cutaneous disease, described as pityriasis rubra by writers of the present day. Even from the scant description of the cases given in the paper, we can confidently say that they were nothing of the kind. Three cases of this rare affection *might* occur in one clinic, but such an occurrence would be so remarkable that one could hardly accept the unsupported statement without more or less distrust of the diagnosis. From the brief notes concerning the patients, we learn that in Case I. the body was covered with bran-like and imbricated scales, piled together in the flexures of the joints, and that the trouble had existed since childhood. Now the flakes of skin thrown off from the body, in a case of true pityriasis rubra, are not bran-like; they are large, and curled up at the edges, which are usually free, instead of being imbricated. According to our experience, the flexures of the joints are the parts most likely to be smooth, and, as far as our knowledge goes, there is no record of the occurrence of this affection in childhood. Still the description given of this case is indeed suggestive of pityriasis rubra, but all doubts are confirmed when we read that a sister of the patient (Case II), as well as the mother and four others in the family, were all affected with a similar condition of the skin!

In Case III, a boy 14 years old, the body, which had been red and scurfy since birth, presented a purplish appearance, and was studded with elevated follicles, whose ducts were plugged with

epithelium. This condition of the follicles, known as *lichen pilaris*, is a common affection, and not infrequently associated with patches of squamous eczema, but for obvious anatomical reasons, it could not possibly exist in a case where the epidermis was constantly being exfoliated, as in *pityriasis rubra*.

It would be unfair to insinuate that these three successfully treated cases were simply one of the protean forms of scaly eczema, but when so many cases of such a rare and intractable affection are reported as successfully treated, the writer is bound to give a full description of the cases, in order to substantiate his diagnosis. *Phil. Med. Times*, Sept. 14, 1877, p. 585.

**On the very frequent connection between eczema and diabetes mellitus.** BRAXTON HICKS states, that of the women who apply to him on account of eczema of the genitals, about eight or nine out of ten have diabetes mellitus in a decided form. This is readily accounted for, by the irritating action on the skin of saccharine urine, but in these cases eczema of other portions of the body is often present, and is not amenable to the ordinary treatment until the glycosuria has been controlled. He mentions the well known occurrence of sugar in the urine of patients suffering from carbuncle, and directs attention to this association of diabetes with general eczema. *Lancet*, March 31, 1877.

**Flexible collodion in cases of eczema.** HENRY LAWSON, treated two cases of eczema, by coating the affected part with flexible collodion, and expresses a desire to know what the profession think on this subject. A woman with eczema of the genitals, of fourteen months standing, was cured in two months. The writer regulated her diet, and administered laxatives, but believes the cure was effected by the local applications.

The second case, a ten year old boy, had eczema capitis. He had none of the signs of scrofula, which, according to the writer, are usual in this form of disease. The hair, which was matted down over the left parietal bone, was cut, and flexible collodion applied. In ten days there was no improvement, but with soda and rhubarb internally, and an abundance of beef tea, the patient had so far recovered in seven weeks, that the hair was allowed to remain uncut, and the collodion only occasionally used. The patient finally made a complete recovery.

[We think that L. has a correct view of local therapeutics, when he advises the use of collodion flexile, "to prevent the action of the air on the malpighian layers of the epidermis, and thus to allow the upper layers to be formed beneath its protective influence." But we think the reason why this remedy is "not mentioned in some of our best hand-books on skin diseases" is, because the writers recommend a number of equally good or better remedies for local use in such cases. While we admire the writer's enthusiasm over collodion flexile, we regret that he rests

its reputation for efficacy upon so slender a basis.—*Rep.*] *Lancet*, June 23, 1877.

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## NEW FORMATIONS.

EDWARD WIGGLESWORTH, M. D.

**Tattooing of nævi.** SHERWELL has a record of five cases of vascular nævi, upon which he has operated by obliteration. The ages of the patients varied from one to thirty-three years. The results were as a whole very satisfactory.

He makes with sewing machine silk a compact bundle of eight needles, with sharpened and roughened cutting edges, and with this he tattoos the nævus, using a 50 per cent. solution of carbolic acid, or one of 25 to 40 per cent. chromic acid. Slight bleeding ensues, followed by slight sanious oozing. (Pressure is kept up all the time.) This is wiped off with alcohol, and several layers of collodion, extending beyond the margin of the nævus, are then quickly applied. This coating endures a week, or less, and is then renewed. In ten days from the first operation a second is performed. No anæsthetic is needed, although ether spray locally may be of advantage. The obliteration is due to adhesive inflammation. No after treatment. There is no pain after the first few hours, merely some rigidity of the part. Sherwell now uses straight suture needles, with shallow grooves on the three sides. He has cured a severe acne rosacea by this means. *Arch. of Dermat., April, 1877.*

**Rhinoscleroma** (Hebra.) MIKULICZ (*Arch. f. Klin. Chirurg. von Langenbeck, XX., p. 485.*) reports two cases of rhinoscleroma, and considers its pathology. The name was given by Hebra some years ago to an affection of the nose and parts adjoining, appearing as nodosities or simple induration, circumscribed, with a smooth surface, more or less shining, and of a normal or reddish-brown color. It undergoes no metamorphosis, does not affect the general health, and resists anti-syphilitic treatment. Kaposi regards it as granular sarcoma (*Virchow's Pathology*); Weinlechner, von Pitha and Hofmokl as syphilitic (Soc. of Med., Vienna, 1870); Geber (*Arch. f. Dermat., 1872.*), as a chronic inflammation; Tanturri (*Il Morgagni, 1872, An. XIV., Dispensa I.*), as an epithelioma or adenoma. Mikulicz agrees with Geber, and endeavors to prove histologically the truth of his opinion. The mass he found homogenous, and quite hard, though yielding readily to the knife. It was primarily composed of rounded cells like leucocytes, universally and equally diffused through the tissues. The sebaceous glands had atrophied from want of nourishment; the vessels furnishing all their nutritive material, under pathological irritation, to the new forming tissue. The epithelium, at first intact, may subsequently ulcerate. The connective tissue of the corium, after being crowded with cells, melts away, and becomes homogeneous.

Mikulicz distinguishes two forms :

I. Cellular infiltration filling the interstices of the primitive tissue, which remains intact. Clinically this form is characterized by simple induration, and change of color of the skin, but without modification of volume. The sebaceous glands and hair follicles are destroyed.

II. More active cell proliferation destroying the tissues first invaded and extending beyond them, producing clinically voluminous nodosities.

The later modifications of the cells are progressive or regressive; in the first case new tissue is formed, with destruction of pre-existing elements; in the second the cells become, as it were, œdematous and degenerated. The muscular fibres may undergo waxy degeneration; or, a part remain normal, while intermediate ones have degenerated; or, may even be transformed into veritable connective tissue; new cells forming and becoming fusiform, thus making a mesh-work the interstices of which are filled with cells still round, which subsequently degenerate, leaving the network of connective tissue to retract.

The process begins in the nasal cavity, and may extend in all directions. Its etiology must be regarded as still somewhat obscure. *Centr'bt. f. d. Med. Wiss.* 21, April, 1877. *Arch. Gén. de Médecine*, December, 1877.

**Lupus erythematosus of penis.** PIFFARD reports a case of excision and galvano cautery of a discolored lupus erythematosus upon the glans penis and prepuce, with good results. He refers to the new views in regard to the histology of this disease, held by Thin (*Med. Chir. Trans.*, LXVIII.), viz: that parts not provided with glands are also affected; and by Geber (*Viertelj. f. Derm. u. Syph. III.*, p. 17.), that the early changes are in and about the capillary vessels. No glands of Tyson were found in sections of the growth. *Arch. of Dermat.*, April, 1877.

**The so-called lupus syphiliticus.** KAPOSI is doing yeoman service in dermatology by substituting an accurate knowledge of disease processes for a verbosity of nomenclature too long existing, and based upon ignorance. Confusion, not clearness, is the necessary consequence of trying to define an individual morbid process by the use adjectively of the appellation of one totally distinct. For example, "syphilitic lupus" does not exist. It is an inherent contradiction in terms, and no writer using the term has ever yet given an exact definition of what he means by it. Clinical resemblance is not pathological identity, and our difficulty is merely subjective, the object demanding for its recognition only better illumination, and more careful inspection. Nor is there any mixed form. Clinically, either disease may give rise to nodules chronically developed, breaking down into ulcerations, which may extend in serpiginous or circular forms, with abrupt borders, subsequently cicatrizing. But those of lupus are smaller, and nearly, or quite painless, the base flabby, red,



granulating, and easily bleeding. Those of syphilis are painful, their borders and bases densely infiltrated and lardaceous. Lupus, primary or relapsing, always begins like pin heads, imbedded deep in the corium, the later, prominent, palpable nodules being of gradual formation by proliferation, and aggregation of the original points. Syphilis begins with a large palpable nodule, as if poured from a mould. Lupus nodules in the early stage are usually found near a serpiginous growth. Syphilis lacks these. Syphilis steadily develops peripherally from a single centre, which lupus does not, may take on a kidney shape, but lupus cannot. Syphilis is an acute process; lupus very chronic, requiring years to produce the destruction caused by syphilis in months, or even weeks. The loss of the alæ nasi by syphilis is as if chopped off; by lupus as if shrivelled up, with scars in the surrounding parts. The bones of the nose may be lost from syphilis, and the hard palate perforated; not so with lupus. Primary lupus begins in early childhood, later appearances representing relapses; syphilis comes at all ages. Lupus yields slowly to treatment; serpiginous syphilis quickly, especially to the local application of empirical medicines, which produce little effect upon lupus. The nodules of lupus melt away before the crayon of argenti nitras; syphilitic ones resist. Lupus is neither contagious nor hereditary; syphilis is both, as is well known. Finally, ignorance of origin, or wishes as to results, do not alter facts. If a virgo intacta, aged fourteen years, of perfectly healthy parents, and of the highest social position, has syphilis, she does have it, and not lupus. *Wien. Med. Wochenschr.*, Nos. 50, 51, 1877, *et seq.*

**Therapeutical action of gurjun oil.** ALKEN cites six cases of leprosy, which were greatly benefitted by the external application of gurjun oil, combined with the administration internally of a maximum daily dose of six grammes of the same. There was no ill effect produced on the stomach and bowels, though sometimes slight itching in the fossa navicularis of the urethra. The amount of urine passed was great, and in direct ratio to the diminution of the infiltration of the skin. No albumen. The increased appetite reported by other authors was not noticed. The catamenia were increased in amount, and rendered painful. The writer prefers gurjun oil to any other means of treatment, as *e. g.*, arsenic, quinine and carbolic, or salicylic acids. The permanence of the good results of gurjun oil is still undecided. The writer alludes also to the favorable results attained under this treatment by Dr. Dougall, at Port Blair. *Fahrh. CLXVIII.*, p. 195. *Schmidt's Fahrh.*, No. IX., 1877.

**Case of lepra maculosa mutilans.** KOEHLER reports the case of a peasant woman of Posen, aged fifty years, and never previously ill, and of healthy parents. She had aborted twice, and borne six healthy children. She had never used ergot, nor suffered from syphilis, lupus, necrosis or traumatic inflammation.

There was no hereditary predisposing influence, for no case endemic or immigrant had been known in the neighborhood since the sixteenth century. She lived in great poverty, with very unhygienic surroundings. A few days after the birth of the third child the disease first appeared, and has lasted fifteen years. The left hand first swelled, turned black, and desquamated, leaving a thin white skin, not cicatricial. The fingers, except the thumb, shrank, and the second and third lost their nails. Neuralgic pains set in, the middle of the forearm took on the whitish appearance, with here and there large crusts covering pus. The second phalanx of the four fingers, and the third of the little finger, were lost, and the whole hand and forearm diminished in size. Sexual passion was not lost. The disease, of course, did not prove contagious. No possible cause except the wretched circumstances of the poor patient could be detected. *Berl. Klin. Wochenschr.* 12, Nov., 1877.

**Leprosy in Guernsey.** LIVEING reports a case of true leprosy in a native of Guernsey, who had never left the island. He regards it as hereditary, however, and not spontaneous, the father of the patient having, when in India, cohabited with a colored woman, and having had at the time of his death sores on his fingers and toes, an enlargement of the nose, and a discoloration of the skin of the face. It is possible that the father may have had leprosy, but for sailors cohabitation is identical with residence in any country, and it is not shown that this, or any other women, colored or white, with whom he there cohabited, had the disease, and it is very doubtful if the disease can be thus communicated. *Med. Times & Gaz.*, Dec. 15, 1877.

**Primary lupus of conjunctiva.** NEUMANN gives an excellent account of this rare form of disease with a case and a bibliography of all other cases thus far published. In his case the general affection, appearing here upon the nose, followed the primary occurrence of a pea-sized lupous nodule upon the inner canthus of the left eye, after an interval of three years.

The conjunctiva of either the lid or the globe or of both may be attacked, and Neumann's interesting and needed article possesses great value for oculists as well as for dermatologists. *Wien. Med. Presse*, No. 293, 1877. *Lond. Med. Record*, Jan. 15, 1877. *Allg. Wien. Med. Ztg.*, No. 52, 1876. *Am. Jour. Med. Sci.*, p. 550, April, 1877. *K. K. Gesellsch. der Aerzte*, Dec. 22, 1876. *Rundschau*, p. 221, March, 1877.

**The development of epithelioma.** BUSCH considers that epithelioma is often preceded by an adherent horny scale from the under surface of which numerous processes protrude into the cutis, probably into the follicles. On removal there is no excoriation, but merely a delicate layer of epithelium covering the hypertrophied papillæ of the cutis. This condition may last for years before the little plugs proliferate and develop into an epithelioma.

Busch insists that the removal of this epithelial growth and the consequent stimulation of the cutis will prevent the formation of the epithelioma. To gain this end, he employs compresses soaked in a 1—2.5 per cent. solution of soda until the layer of abnormal epithelium has been removed, and subsequently the daily washing with a 0.5 per cent. solution of the same. The same treatment is prophylactic against relapses. A few cases of ulcers rodens he has even cured by this method. When the more hypertrophied papillæ in the course of the ulcer resist this treatment, after the cure of the periphery, compresses of acetate of lead (1 to 10 or 12) and pressure often succeed in causing these to shrink, after which the soda may be resumed. The same treatment may be employed for the warty formations upon the breasts of elderly women. *V. Langenbeck's Archiv.*, 21 Bd. *Wien. Med. Wochenschr.*, No. 49, 1877.

**A novel form of epithelioma.** DALBY found a pedunculate wart upon the prepuce, which showed the onion-like arrangement of cells, also globular epithelial cells in the centre and flattened ones in the periphery, but entire absence of the cylinders. *Mo. Microsc. Jour.* *Lond. Med. Record*, May 15, 1877.

**Epithelial proliferation and cancer.** FRIEDLÄNDER shows that a stratified layer of epithelium may cover the ulcers of lupus, or those from varicose veins, etc., coming from pre-existent epithelium, the epidermis, the cells of the hair follicles, etc., and having nothing to do with recovery. The same may take place after skin grafting. True recovery depends upon formation of vascular granulation material, and the transformation of this into firm permanent fibrous tissue. The epithelial formation is primary and independent of the subsequent action of subjacent tissues. It may however send ramifying proliferations downwards into the granulation tissue, where they anastomose in every way, and imitate most exactly the histological appearances found in young cancerous growths. The diagnosis of cancer in its earliest stage cannot therefore be justly grounded upon microscopic appearances solely. The question always remains: why is this formation at one time and under certain conditions relatively benignant, and yet malignant under other circumstances? *Path. Anat. Untersuchungen*, Strasburg, 1877, 8°. J. Trübner. 57 Seiten und 2 Tafeln. *Berl. Klin. Wochenschr.*, No. 6, Feb. 5, 1877. *Centralbl. f. d. Med. Wissensch.*, April 14, 1877.

**On the minute anatomy of two cases of carcinoma of the breast, preceded by eczema of the nipple.** BUTLIN found in two cancers of the breast dilatation of the ducts, alteration of their epithelium and infiltration of the surrounding tissue with small cells, and the same condition in the small ducts, and acini with fusion into large irregular spaces, and escape of the contents or growth of the contents into the surrounding tissues. The same conditions were present in the cases of two breasts

which were the subject of a communication to the society at its last session (Trans., Vol. I.IX.)

Paget and Thin spoke of the connection between cancer and a previous eczema or other irritative disease of the skin, a connection pointed out some dozen years ago by Hebra, in lecturing upon eczema of the head. Hulke and Fayrer spoke of the epithelial origin of cancer and the possibility of tracing the process from simple proliferation of epithelium to an epithelioma from irritation of a lip or cancer from the cicatrix of a burn. Roy. Med. and Chir. Soc., London. *Med. Times & Gaz.*, Feby. 10, 1877.

**Temperature of sarcomata.** ESTLANDER shows sarcomata to possess a temperature surpassing that of arterial blood, due possibly to the activity of the morbid process. This explains the general fever in patients with rapidly growing sarcomata. The increase in temperature is proportionate to the rapidity of growth, of tumors generally, *i.e.*, a hot tumor grows rapidly and is probably a sarcoma. *Nordisk. Medic. Arkiv. Bd. IX., No. 1*, 1877. *Gaz. Hebd.*, p. 417, June 29, 1877. *Med. Record*, Sept. 1, 1877.

**Sarcoma of the nose in a syphilitic patient.** VON VAJDA reports that a man, aged twenty-four, had had syphilis three (!) times. Seven months ago he had a tumor as large as a pigeon's egg on the septum nasi. This is now smaller, but covered with fungoid excrescences which bleed readily. It is not sharply defined posteriorly. Microscopically, it consists of small and large round cells, with some spindle and giant cells, with numerous nuclei. Some of the cells have undergone mucous degeneration as in malignant growths, whereas in gummata it is the inter-cellular substance which is chiefly affected, and the connective tissue elements rarely also proliferate. Imp. Roy. Soc. of Vienna. *Lond. Med. Record*, May 15, 1877.

**Multiple lipomata after typhus.** WOLZENDORF relates the case of a peasant, aged 21 years, who, after typhus fever lasting six weeks, noticed several movable nodules as large as hazel-nuts upon the flexor aspect of both forearms. These increased in size and number with great rapidity, new ones appearing almost daily upon various parts of the body. Within a fortnight these were forty-two in number. Of these sixteen were on the right and eleven on the left thigh. Subsequently their growth was slower and finally imperceptible. Microscopically, they proved to be lipomata. *Deutsche Zeitschr. f. Chir.*, VII., p. 369. *Centralbl. f. d. Med. Wissensch.*, April 2, 1877.

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## PARASITIC DISEASES.

GEORGE H. ROHÈ, M. D.

### I.

#### ANIMAL.

**Cysticercus cellulosa in the skin.** LEWIN has published three cases:—In the first case there were five tumors under the skin, varying in size from a cherry-stone to a hazel-nut; of an elastic consistence, but not painful. Microscopic examination demonstrated the presence of cysticerci. There were no other

symptoms except intense paroxysmal headache, which was ascribed to a similar tumor in the brain.

The second case presented a large number of similar tumors. No other symptoms except asthmatic attacks. In the third case there was a parasitic tumor, of the size of a hazel-nut, below the left nipple.

Lewin thinks that the discovery of cysticerci in the skin justifies the conclusion that certain coincident symptoms usually present, depend upon the existence of these parasites in internal organs, such as eye, the brain, intestines, etc.

The true nature of the affection is not always recognized. It has been frequently mistaken for echinococcus or trichina; and not rarely have the tubercles been confounded with the nodules of lupus, fibro-plastic or cancerous tumors, and gummata. The author expresses the opinion that the cysticercus may traverse the tissues, basing it upon the changeability of the cephalic symptoms when the parasite infects the brain, and upon three cases recorded by Von Græfe, where the cysticercus had traveled from the eye to the brain and *vice versa*.

The length of time during which the parasite may remain in the human organism depends upon the nature of the organ attacked. Thus, in the eye, it soon gives rise to severe inflammatory symptoms. In internal organs, on the other hand, for example, in the brain, it may exist seven, nine, or even twelve years from the time its presence is first manifested by epileptiform attacks.

Infection may occur in two ways: directly, from the ova of a living tænia in the intestine of the individual, or indirectly, by the ova of a tænia from another individual.

Lewin does not consider the symptoms observed in the nervous circulatory or respiratory system, due to reflex action from irritation of the intestinal canal; but to the presence of cysticerci in those organs themselves. He says those portions of the intestinal canal where tænia are generally found, are precisely those that rarely give rise to reflex symptoms when irritated.

The only treatment recommended is excision of the tumor, or emptying the vesicle by a puncture and injecting a few drops of alcohol. Internal treatment by mercury, arsenic, benzine, etc., is of no avail. Prophylaxis, therefore, becomes important, and this, it will be readily understood, is the avoidance of all raw or under-done meat. *Charité-Annalen*, 1877, p. 609. *Rev. des Sciences Médicales*, 15 Jan., 1878.

GUTTMAN also reports a case of cysticercus in a man aged 63. There were about thirty-six small tumors scattered pretty well over the entire body. They were immediately under the skin and moveable; tense, elastic, nearly as hard as cartilage. They were painless and varied in size from a cherry-stone to a hazel-nut. Extirpation of tumors and microscopic examination revealed cysticerci. New tumors were constantly forming. There were

no symptoms indicating the existence of the parasite in other organs. *Berlin. Klin. Wochenschr.* No. 26, 1877. *Centralblatt f. d. Med. Wissenschaften*, Dec. 29, 1877, p. 960.

**Animal parasites of the external ear.** TRAUTMANN gives the results of his observations on the parasites of the ear in animals, and calls especial attention to the possibility of the external auditory meatus becoming infested with them.

There are three species of mites harbored by animals: the *dermanyssus avium*, *lithoeum avium* (hen louse), and the *dermatodectus cuniculi*. Severe symptoms are often caused by parasites in the ears of dogs and rabbits, and death of the animal is a not unfrequent consequence. The dermatodectes or dermatocoptes are found on the skin of rabbits, dogs, and sheep. According to Gerlach, they remain but a few hours upon the human skin, but Trautmann thinks they could very easily develop in the human auditory meatus.

When the mites penetrated into the labyrinth of the animals which were the subject of experiment, death speedily occurred with well-marked symptoms of meningitis. *Berlin. Klin. Wochenschr.*, Feb. 9, 1877. *Balto. Mirror*, August 1877.

**Eczema intertrigo caused by oxyuris vermicularis.** MICHELSON has observed a case of intertrigo of an eczematous character, which he believed was caused by the presence of the ova of pin-worms in the genito-crural fold. The exciting cause may have been either the scratching, or the imbedding of ova in the epidermis. The observation was made that moist warmth alone did not suffice for the development of the ova, but that the presence of gastric juice was necessary. The affection rapidly disappeared on using a dusting powder of salicylic acid, one part, and pulv. starch, five parts. *Berlin. Klin. Wochenschr.*, No. 33, 1877. *Centralblatt f. d. Med. Wissenschaften*, Jan. 12, 1878, p. 25.

**Demodex Folliculorum.** P. MÉGNIN publishes a memoir on this parasite. The demodex folliculorum belongs to the order of *acari*, but not to the family of the *sarcoptides*, to which latter the itch insect belongs. It constitutes, according to the author and Prof. Gervais, the only genus of a family of demodicides. There are different species upon different animals; the demodex of man differs from that of the dog, cat, sheep, etc. This difference can only be made out in the larval state, since the adult mites resemble each other in a high degree.

The demodex lives and multiplies in the sebaceous and hair follicles. The variety occurring upon the dog occupies indifferently the hair follicles of the whole body; that upon the cat, particularly the sebaceous glands of the ear, while the ovine variety only inhabits the meibomian glands. Gruby, impressed with the idea of the identity of the demodex of the dog, and of man, recommended strongly the avoidance of animals infested by the insect. This is

unnecessary, according to Mégnin, because the varieties occurring upon the dog, cat, sheep, etc., do not affect a lodgement upon the human skin. *Journal de l'Anatomie de Ch. Robin, March, 1877. Rev. des Sciences Medicales, July 15, 1877, p. 186.*

**Oil of stavesacre in scabies.** B. SQUIRE recommends the use of the fixed oil of stavesacre, obtained by expression, as a colorless, odorless and unirritating remedy in the treatment of scabies. *Brit. Med. Journal, June 16, 1877.*

## II.

### VEGETABLE.

**Parasitic diseases, and the systematic botany of vegetable parasites.** P. GRAWITZ publishes an account of a series of experiments upon the biological and clinical relations of the parasitic fungi. The results of his experiments have led him to the conclusion that achorion, trichophyton and microsporon are but vegetating forms of oidium lactis. The form of Morph that appears in any one case depends upon the nature of the soil. The soor fungus is not oidium, but a form of mycoderma vini. [Apparently an attempt to give renewed life to Hallier's views.—Rep.] *Virchow's Archiv. Bd. 70, p. 546. Centralblatt f. d. Med., Wissenschaften, Dec. 15, 1877, p. 902.*

**Are the vegetable parasitic affections of the skin due to one or to several parasites?** McCALL ANDERSON devotes a chapter to the consideration of this question. The evidence in favor of the nonidentity of the different parasites is given, but nothing new is added.

**Treatment of favus.** SAWICKI uses a paste of pulverized chalk or gypsum containing 5—10 per cent. of carbolic acid. This is applied all over the head after cutting the hair short. On the third day the dressing is removed, the head washed with soft soap and water, and the paste reapplied. A little oil may be added to render the dressing more pliable. It is said to effect a cure after three or four applications. *Przegląd lekarski Krakowski, No. 34, 1876. Viertelj. f. Derm.-u. Syph., 1877, 1 & 2, p. 283.*

**Tinea trichophytina.** In a clinical lecture, WHITE points out the danger of contagion from domestic animals and pets, especially kittens. The remarks on treatment are full and judicious. *Boston Med. and Surg. Journal, Feb. 14, 1878, p. 191.*

**Eczema marginatum.** A valuable, practical paper by BULKLEY, read at the first annual meeting of the American Dermatological Association, gives details of twelve cases. A summary of the paper with report of the discussion upon it has

already been published at p. 57 of the January number of this journal. The paper is published in full in the *Chicago Med. Journal and Examiner*, Nov., 1877.

**A new remedy in certain forms of skin diseases.** DR. J. IVOR MURRAY learned the use of the remedy while in China. He has had remarkable success from its use in ring-worm, eczema marginatum, and eczema. The Chinese make a tincture from it using arrack as a menstruum. It is sold in London under the name of "*Fluid Extract of Tong Pang Chong*." Mr. Jackson, curator at Kew Museum pronounces the specimen (root) submitted to him to be "the produce of a berberideous plant, and nearly identical with *akebia quinata* (Decaisne). A crystalline substance has been extracted from it which may prove to be allied to chrysophanic acid. *Brit. Med. Journal*, May 19, 1877.

**On ring-worm and its management.** Fox gives a long paper in his well-known gossipy, somewhat tiresome style. It is worth while noticing that he discards the theory of the parasitic origin of alopecia areata, which he formerly defended. *Lancet*, Oct. 27, Nov. 3, 10, 17, 1877.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### INFANTILE AND CONGENITAL SYPHILIS.

JAMES NEVINS HYDE, M. D.

**Marriage of syphilitic patients.** FOURNIER, in discussing the important questions which arise in connection with the subject of the marriage of syphilitic patients, does not entirely exclude the latter from marital relations. The conditions of admissibility to the matrimonial state, are thus given : 1, Absence of actual lesions ; 2, advanced age of the diathesis ; 3, a certain period of immunity consecutive to the last manifestations ; 4, benign character of the disease ; and, 5, sufficiently prolonged specific treatment.

Under the first head, the author describes the ignorant, vicious or feeble-minded individuals, who enter into the marriage state suffering from syphilis ; even in some cases affected with primary lesions. Upon the second point, the axiom is formulated that the younger the syphilis, the more manifold and grave the danger. The marriages the most ominous for offspring, are those in which the syphilis of the father has existed for from a few months to three years. From the fifth to the tenth year, the hereditary influence is markedly diminished. But the age of the syphilis is not to be taken as the sole guide. With it, are to be considered

the nature, duration and results of treatment. The minimum period which should elapse between infection and marriage, is stated to be three or four years—that is, taking into consideration merely the question of time.

Upon the third point, the author remarks, that the best proof of the non-activity of the diathesis is the interval without accidents which has succeeded the period of acute syphilitic manifestations. The duration of this interval cannot be exactly determined by a general law, but, due allowance being made for the greater or less severity of the last explosion, it may be said that it would be imprudent to make this period of immunity less than from eighteen months to two years. Considering the fourth division, Fournier makes the following classification of "menacing" cases: (a) benign syphilis, accompanied by frequent recrudescence of mild symptoms; (b) syphilis, grave in consequence of multiplicity, intensity, nature or tendency of symptoms; or on account of the reaction excited in the general condition of the system; or, finally, from its proving refractory to treatment: (c) syphilis, particularly grave from its predilection for certain important organs essential to life.

Upon the last division of his analysis, the author naturally reposes great weight, believing that a methodic specific treatment, prolonged for years, diminishes or suppresses the chances of contagion and the risk of hereditary influences, after the marriage of the syphilitic patient. *L' Union Médicale du Canada. June, July, August and Sept., 1877. Vol. 6, Nos. 6, 7, 8 and 9. Four. de Méd. et de Chir. prat. July, 1877, p. 302. Gazette Obstét. June 20, 1877, No. 12, p. 185.*

DR. DRYSDALE's views on the subject of syphilis and marriage are eminently judicious, since they are founded upon a just consideration of the history of the disease, and are, as a matter of fact, those which are accepted by the mass of syphilographers. But they are not presented with that systematic accuracy which has made the contribution by Dr. Fournier on the same subject, so acceptable to his many readers. (*The Doctor, July 1, 1877*).

**On the transmission of syphilis after infection late in pregnancy.** In a clinical lecture delivered at the London Hospital, MR. HUTCHINSON records some cases which are supposed to show that syphilitic infection of the mother, even during the last weeks of her pregnancy, may entail her disease upon her offspring—an extreme view, only equalled by that of Diday, who claims that the ovum, as soon as impregnated, may infect the healthy mother.

In the first case, the mother contracted chancre six weeks before confinement, and exhibited symptoms of constitutional disease after delivery, when her infant showed copious pustular syphilis, dying subsequently, before it had reached the age when strictly hereditary syphilis is generally manifested. In the second case,



the mother had chancre five weeks before confinement ; and, two months after, the primary sore still existed, when her infant suffered from a rash. The father was under treatment for more than a year. When five years old, the child had interstitial keratitis, arthritis and tibial thickening ; and, in the tenth year, though in fair health, the traces of the disease were unmistakable. In the third case, the mother came under observation five weeks after delivery, for chancre of the tongue, which she had noticed six weeks before. Pustular syphilides had been present for three weeks. The child, healthy until eight weeks, had then a well-marked syphilitic rash, and subsequently recovered under treatment. The date of infection of the mother in the fourth case, was not ascertained. She was in her third pregnancy, had previously borne two healthy children, and was delivered of a girl who had a history of prolonged symptoms in infancy, and, at twelve years of age, troublesome keratitis and characteristic teeth.

[The new departure of Mr. Hutchinson consists in his attempt to distinguish between the symptoms of "strictly inherited" syphilis, and that form of disease which, it is claimed, results from trans-placental infection. It would thus appear that while the fœtus transmits to its mother a disease which is often only capable of recognition by the immunity which is thus conferred upon her ; she, on the other hand, is capable of transmitting to her unborn child, even in the last weeks of pregnancy, a disease which may speedily result in the loss of its life.—*Rep.*] *Med. Times and Gazette. Canada Med. and Surg. Journal. Oct., 1877, No. 64, p. 174.*

**Re-infection in hereditary syphilis.** DR. DOWSE read notes of a case of a nine-year old girl, whose mother had had eight miscarriages, and whose upper incisors were notched and irregular, but yet who gave no history of congenital syphilis. While carrying upon the arm the child of a neighbor, affected with mucous tubercles of the anus, she inoculated a scratch upon the flexor surface of the right forearm. She subsequently suffered from emaciation ; ulceration of the *alæ nasi*, pharynx, larynx, trochea and bronchi ; ulcerating lenticular syphilide ; and rupioid crusts. The case terminated fatally.

Dr. Dowse called attention to the possibility here suggested, that primary syphilis could be acquired by the subject of the hereditary disease ; to the possibility that the nasal disorder might have been lupoid in character, modified by the syphilitic dyscrasia ; also to the rarity of rupia in children, seldom encountered by Zeissl, never by Cullerier. (*Clinical Society of London. Med. Times and Gazette, June 9, 1877, p. 630.*)

**Syphilis of the placenta.** M. BRÉBANT reports the case of a woman who first aborted at the fifth month. Suspecting paternal syphilis, the mother was treated by the administration of the

iodide of potassium in a second pregnancy, and bore a puny infant who subsequently thrived. No medication was attempted during a third pregnancy, when a dead fœtus and placenta, of between five and six months' development, were expelled at the eighth month.

On section, seven or eight small, nut-sized tumors were discovered in the thickness of the placenta, upon its internal face. They contained in their centre, but more particularly in the superficial portions, a gelatinous substance, surrounded by greyish matter of considerable consistence. *Union Médicale et Scien. du Nord-Est. Reims, No. 7. July 31, 1877, p. 220.*

**Chancre of the nipple.** The report of DR. STURGE includes three cases. In the first, a healthy woman, who gave her breast to the hereditarily syphilitic child of a neighbor, had a small, superficial, indolent erosion on the outer side of one nipple, the lesion increasing in size, until it presented the appearance of a syphilitic chancre. The patient herself noticed the induration. When the chancre was almost healed, an hypertrophied syphilide developed *in situ*. Axillary, cervical, and inguinal adenopathy followed, with a papular exanthem. The history of the mother of the child nursed by this patient, is also appended, and is conclusive as to syphilis. Her child had a specific erosion on the lip.

In the second case, the wet nurse of a premature, three-weeks-old child having snuffles and yellow patches upon the tongue and lips, noticed a little pimple on the areola surrounding the nipple of the left breast, fifteen days after her first nursing of the infant. This lesion increased to the size of a half-franc piece, ulcerated, crusted, and finally covered with a scab. In three weeks a similar lesion appeared on the areola, just above and outside of the nipple of the other breast. Indolent, slightly ulcerated, and characteristically indurated when first examined, M. Fournier at once pronounced them to be primary syphilitic sores. Here also axillary adenopathy and an exanthem succeeded.

In the third case also, a mother nursed the child of a neighbor having patches in the mouth, and in eleven days she had two pimples on the right breast, close to the nipple, and five upon the left. These enlarged, and became indurated, when a chemist applied strong mercurial ointment, and phagedena resulted. Upon examination, deeply excavated sores surrounded about two-thirds of the nipple of each breast, with hard, slightly elevated margins, and an unhealthy, sloughy-looking floor. The neighboring parts of the mammæ were red, swollen, and very tender.

An interesting example of the converse of these cases was cited, where a wet nurse, having mucous tubercles of the lips and tongue, had charge of an infant who habitually put its fingers into the mouth of the one who nursed it, and afterward carried

them to its own mouth. M. Fournier found a syphilitic primary sore on the tongue of this child, who had in the same way inoculated its father, mother and grandmother with the disease—as well as several other individuals, all of whom after a time exhibited syphilitic chancres of the lips or tongue.

[In commenting upon these cases, Fournier lays stress upon the practical points, so often set forth in these pages, and calls attention to the danger of employing a nurse until she has survived the incubative period of chancre.—*Rep.*] *Report to the Med. Times and Gazette, Aug. 1, 1877, p. 116.*

### Non-transmissibility of syphilis through the milk.

DE AMICIS contributes an interesting observation relative to the question of the non-transmissibility of syphilis by the medium of the milk :

Annie R., æt. 40. had always enjoyed good health in her youth, and was married in her 22d year. In the first six years after her marriage she had two sons, who are now living and in good health. Her troubles began twelve years ago, when she was nursing her third infant. At that time she had an abundance of breast milk and her child was vigorous, when a neighbor, who had lost her own child, adopted a sickly and emaciated infant taken from a foundlings' home. Sgra. R. was urged to give her breast for a brief time to this sickly child.

The little stranger was nursed for but one day only, as it was then seen to have a sore mouth and an eruption over the skin ; and these facts induced Sgra. R. to refuse to nurse it longer. She had reason only too soon to repent of her charitable conduct. A crack appeared upon the left nipple, considerable tumefaction resulted, and she was threatened with suppurative mastitis ; but the inflammation subsided under the usual treatment. An induration, however, remained in the site of the fissure, which occasionally pained her. Ignorant of the nature of this disorder, she continued to give her breast to her own healthy child ; but, in a few months, she found her own skin covered with a maculo-papular eruption, accompanied by cephalalgia and peri-articular pains. The child, too, soon had ulceration of the buccal cavity, adenopathy, progressive impairment of nutrition and cachexia ; it subsequently died.

The mother continued to suffer from pain for several months afterward, and her cutaneous disease rapidly assumed the pustular type (ecthyma). She was submitted to treatment, of the nature of which she is ignorant, including the employment of the thermomineral baths of Ischia, without receiving any benefit, the pains increasing, and the cutaneous disease remaining unaffected.

Six years elapsed, during which treatment of various character was employed, with no better results, except that she had periods of exacerbation and repose of the malady.

She was seven times pregnant in this interval. The first three

pregnancies resulted in abortion between the third and fifth months. In the other four the children were carried to term, the first two surviving but a few days, the others reaching the age of three years, when they died of typhoid and diphtheritic disorders, without having ever manifested lesions of the skin. After the first two of the last pregnancies—those in which the children died soon after birth—she had again an abundance of breast milk, and, dreading its sudden suppression, she suckled two children (one after each pregnancy). These children were then in good health, and are now living, vigorous and rosy, their appearance being the best evidence as to their excellent general condition.

In 1874, ten years after her infection, she became pregnant for the last time, and then noticed on her face (especially about the right cheek), the arm of the same side, and the left thigh and foot, certain reddish nodules, which healed after ulceration, leaving more or less deep cicatrices, which are still visible.

This pregnancy was concluded at term, and she bore a well nourished and well developed child, which she nursed, and which remained free from all evidences of disease up to the seventh month. She found, however, that she had not sufficient milk for this infant, and hence arranged with her cousin (whose own child was dead, and whom she believed to be in sound health), that the latter should give the child her own breast. She subsequently discovered that this cousin had a maculo-papular eruption upon the skin, similar to that from which she herself had formerly suffered, as well as rhagades of the nipple. Two months afterward, the baby had aphthæ of the mouth, and a skin disease quite like that observed in her own case. The infant was soon relieved of these symptoms; but in 1875 small pustules appeared about the nates and genitals, and spread over the surface from these points. Simultaneously the mother developed tubercles over the right and left elbows, which ulcerated, and on one side resulted in the limb being semi-flexed. Other tubercles appeared over the os frontis, sternum and tibia, occasioning excruciating nocturnal pain and more or less distress throughout the year 1876.

Such was the history of the case, and the examination of the patient fully confirmed its essential accuracy. Over the sinciput were various irregularities of surface, due to loss of osseous substance beneath, cicatrices closely adherent to subjacent tissues, and brownish crusts, beneath which were perforating ulcers of lardaceous aspect. Over the central part of the frontal region, a depressed, adherent, V shaped scar was seen, the osseous tissue centrally having been absorbed, surrounded by peripheral hyperostosis. Over the temporal regions and cheeks were circular and oblong, whitish cicatrices, interspersed here and there with cherry-sized tubercles, some in course of degeneration. Over the manubrium of the sternum was a reddish hemispherical tumor as large

as a silver dollar, painful on pressure. Still another depressed, adherent cicatrix was found over the left clavicle. An enormous area of cicatricial tissue extended also from the inferior fourth of the right arm to the inferior third of the forearm; indurated, adherent and covered here and there with round, oblong and semi-circular ulcers of foul base. At this point also, irregularly shaped cicatricial bridles had produced pseudo-ankylosis of the elbow-joint, evidently not due to bicipital contracture. Adherent cicatricial patches, surrounded by clean cut ulcerations, showing a foul base and abundant discharge, extended also from the lower third of the thigh to the inferior fourth of the leg. The diaphysis of the left tibia was double its normal size, and tender on pressure. The patient complained of cephalalgia and nocturnal and osteocopic pains. There was no albumen in the urine.

The child, when examined, was found to be emaciated and weak, the head also being disproportioned to the size of the body. Its incisor teeth were not deformed. Yellowish, grey and brown fatty crusts covered its scalp, beneath which were superficial excoriations of reddish-white aspect and indeterminate margins. There was cervical and submaxillary adenopathy, some of the glands being as large as a pigeon's egg; one, on the right side, had suppurated. Punctiform cicatrices, light reddish brown in hue, were to be seen over the abdomen and back. The tumefied labia majora and minora showed flat, grey, ulcerative patches, which also extended to the anus and nates. The inguino-crural glands were as large as almonds. *Annal. Clin. dello Osped. Incurab., Sept. and Oct., 1877, p. 278.*

**Syphilis and abortion.** PROFESSOR GOODELL, in a clinical lecture on a case of congenital syphilis, exhibited the dead body of an infant, born of a mother who had been prematurely delivered on eight occasions. The lecturer dwelt upon the danger to the medical attendant officiating in labor, where the product of conception was syphilitic, and expressed the belief that the "liquor amnii of a syphilitic fœtus is abundantly able to inoculate the accoucheur with the poison." Placental lesions were explained by the occurrence of inflammation, with exudation pressing the blood out of small capillaries, gummy tumor, fatty degeneration, and atheroma of the vessels of the cord. *Phil. Med. Times, Jan. 19, 1878, p. 169.*

**Boeck on inherited syphilis.** PROF. BOECK believes that, as a rule, a female who becomes syphilitic before puberty, gives birth to healthy children, exceptions however occurring. If, on the contrary, the disease is contracted after puberty, it is rare that she gives birth only to healthy children. Recognizing the order, so frequently noted, of diminishing syphilitic phenomena in a series of births, he notes three exceptions when syphilitic succeeded healthy children. When a woman who has had syphilis gives birth to a healthy child after having borne those which were syphilitic,

it is by no means a rule that she continues to give birth to healthy children ; she may have several syphilitic children, dead or putrid fœtuses, before she again gives birth to a healthy child. When syphilis is contracted during the last two months of pregnancy, the child will be spared. A mother with tertiary syphilis, will possibly bear healthy children. The author knows of but one case where syphilis was communicated from the father to the child. Hereditary syphilis is due almost exclusively to the mother. The variation in its degree depends upon the period which has elapsed since maternal infection. Boeck does not remember to have seen the disease occur after the fifth month, and only once at so late a period. The prognoses of the hereditary and acquired forms are infinitely different.

In the way of treatment, mercury and syphilization have given the best results. The death percentage of the former was 45, of the latter 46. At the age of from one to two months, the mortality from mercury was 52 per cent., with syphilization 65 per cent. In the period between six and twelve months, with mercury 29 per cent., with syphilization 11 per cent. Iodide of potassium, partly direct, partly by the mother's milk, gave a death percentage of 72. Researches on Syphilis. *Undersøgelser Angaaende Syphilis*. Christiania, 1875, 415, p. 292. Bibliographical Note in the *New York Medical Journal*. Nov. 1877, No. 152, p. 538.

**Syphilis transmitted by vaccination.** It is reported that in a small village near Frankfûrt on the Oder, twenty-six children were vaccinated from a vaccinifer, subsequently found to be the victim of hereditary syphilis. Twelve are said to have escaped infection, while the remainder suffered from constitutional disease. *Gazz. Med. Ital. Lomb.*, Feb. 2, 1878, p. 50.

**Syphilis and vaccination.** MR. LANE merely discusses the questions already suggested in Mr. Hutchinson's Illustrations, and expresses his belief that a healthy person, inoculated with lymph from a diseased child, could not in one week elaborate a lymph capable of infecting others vaccinated with it, because the blood-mass could not in such time become thoroughly poisoned. Early general infection seems to him impossible ; but, as to the secretions, whether natural or morbid, which are derived from diseased blood, he can see no reason why they should not partake of the contagious quality of the fluid from which they are formed *Lancet*, April 21, 1876, p. 562.

**On Colles' Law.** The editor of the *Medical and Surgical Reporter* cites a paper published in the *Medical Times and Gazette*, May 19, 1859, written by Dr. James McCraith, Surgeon to the British Hospital, Smyrna, in illustration of what is erroneously termed an "extension of Colles' Law." The attempt is made to show that a syphilitic infant, whose disease was not derived from its mother, was incapable of infecting the latter, and yet com-

municated the disease to its nurse. [The blunder lies in supposing that the child had *hereditary* syphilis, for, by consulting the original communication from Dr. McCraith (which, by the way, displays the author's want of familiarity with the history of syphilis) it will be seen that the infant was affected with the *acquired* disease, all questions pertaining to heredity being thus excluded.—*Rep.*] *Phil. Med. and Surg. Reporter*, April 21, 1877, p. 360.

**Placental and other internal lesions in hereditary syphilis.** DR. DE SINÉTY, presented to the Anatomical Society, the liver, kidneys and placenta of a dead-born fœtus, whose mother had been twice before delivered of still-born children, and who admitted syphilitic antecedents. The hepatic and renal tissues, under the microscope, appeared to be infiltrated with minute round elements, in places dissiminated throughout the parenchyma, and in places constituting small islets similar to those described by Charcot and Parrot. In the kidneys there was thickening of the connective tissue, in some places more advanced than at others.

There was such enormous development of the placenta, that prior to delivery the mother was supposed to be carrying twins. The hypertrophied mass was pale and whitish in hue, less consistent than in the normal state. Some of the villi were enlarged threefold, some unaffected. In the larger number of the hypertrophied villi, the vascular elements had disappeared; those containing unaltered blood-vessels were chiefly found on the uterine aspect of the placenta.

The reporter considered these alterations the first stage of the condition which would eventuate in hydatiform mole, or myxoma of the placenta, described by Klob in 1864 as "œdema;" the lesions affecting chiefly the fœtal portion of the placenta while the maternal elements remained in a normal condition. *Le Progrès Méd.* Dec. 1, 1877, p. 911.

**Chancres in children.** LETULLE reports several cases of chancre of the vulva in children, which are supposed to have originated in consequence of the shocking delusion existing in France, that an adult affected with syphilis can be promptly and rapidly cured by contact with a female child.

In the first case, the primary lesion was discovered on the internal face of the right labium majus, about one centimètre below the clitoris, in the form of a perfectly rounded ulceration, of rosy tint and pale centre, with regularly projecting smooth and flattened borders, covered with delicate granulations, seated upon a scarcely perceptible induration one centimètre in breadth, and not surrounded by œdema of adjacent parts. Inguinal adenopathy co-existed, and general syphilis followed.

In the second case, a rounded, slightly projecting ulcerated surface, one centimètre and a half in diameter, was discovered on the internal face of the left labium majus, at the level of the clitoris.

Its edges were of a rosy color, its floor granulating and secreting a thin yellowish serum. There was some tumefaction of the adjacent parts, without induration; one portion of the ulcer seemed to be in the phase of cicatrization. Small, superficial lesions, destitute of characteristic features, were found upon the corresponding part of the right labium. Inguinal adenopathy co-existed, and general syphilis followed.

In the third instance, a circular, rosy-tinted ulcer was found on the internal face of the right labium majus, slightly above its centre, one centimètre and a half broad, slightly indented, its surface weeping, covered with granulations, and exhibiting a trace of cicatrization at the edge. There was marked right inguinal and crural adenopathy. On the corresponding part of the left labium were three rosy-grey lesions, with borders less distinctly rounded than those described above. The hymen was intact.

In the fourth case, a rosy-tinted lesion, without subjacent induration, was seen on the labium majus at the level of the clitoris.

The author concludes, (a) that infecting chancres of the vulva in children are relatively frequent, considering their rarity in the adult; (b) that their most common site is the internal face of the labium majus in the vicinity of the clitoris, corresponding thus to what Dolbeau has described as the superior and most projecting point of the "vulvar canal;" (c) that in course and duration they do not markedly differ from similar lesions in adults, the secondary sequelæ being more or less rapid in onset; (d) that, in a medico-legal point of view, the recognition of the site may furnish valuable evidence in the conviction of criminal parties; and (e) that acquired syphilis, in children, is often the consequence of a popular delusion which should be by all possible means be removed. *La France Médicale*, Jan. 30, and Feb. 6, 1878, pp. 65 and 81.

**Syphilis inherited through two generations.** The interesting paper of DR. ATKINSON has appeared in full in the columns of this Journal. We merely remark of it that, difficult as is the task to trace the descent of syphilis through two generations and to rigidly exclude all sources of acquired disease from the subjects under consideration, the author has succeeded well in amassing the necessary details. The important features of this history are: (a) the somewhat exceptional character of the disease in the first inheritor, and (b) the typical character of the same disorder in the second inheritor—the child of the former patient. *Archives of Dermatology*, Jan. 1877, p. 106.

**Mr. Lane on hereditary syphilis.** MR. LANE'S lecture, which occupies fully five columns of the Journal in which it is reported, does not contain, so far as we are aware, a single new fact or suggestion bearing upon the subject of which he treats. He very briefly touches upon the researches of Kassowitz, but has made his compilation chiefly from the published papers of his English cotemporaries, Hutchinson, Broadbent, Berkeley Hill and



Henry Lee, whom he quotes with unexceptionable manner and undisguised deference.

In declaring that the evidence is altogether negative as to the occurrence of contagion in tertiary syphilis, he discredits the observation of a well-known American author, with whose researches a gentleman in his position might be presumed to be acquainted. *Lancet, Amer. Ed., Sept. 1877, p. 384.*

**Inherited syphilis and cleft palate.** DR. BROWN, concludes after consideration of six cases (four of his own observation) in which syphilis and cleft palate were associated, that "there was more than a simple concurrence"—in other words, that syphilis may prove to be a factor in the production of the deformities named. [The question pertinent to the paper, however, is, whether syphilitic disease could have produced the deformity noted in the author's four cases. And a logical answer, based upon so much of the record of these cases as the author has chosen to publish, must be in the negative. For, while the syphilitic parental history is given, there is no record of the disease in the children except in the first case, where a mucous patch "attacked the line of the incision," made to correct the deformity. Even here it is by no means clear that the child did not acquire the disease after birth.

It is of course essential to the decision of the issue raised, that there shall be an unequivocal history of hereditary disease. Syphilis of the parents—one or both—while it may be conceded as raising a presumption in favor of diseased offspring, is by no means necessarily followed by such transmission, as there is abundant clinical evidence to show.—*Rep.*] *Archives of Dermatology, July 1877, p. 307.*

**Hereditary syphilis and hydrocephalus.** DR. PORTER treated a female infant, six months old. The mother, aged 29, had had eleven children; some still born, or dead when very young; two living—the oldest (born in her fifteenth year), and the patient. The mother admitted syphilis, and stated that two children died of "water on the brain."

[The reporter announces that the evidences of hereditary syphilis were "well marked;" and that the child had unmistakable marks of hydrocephalus. Recovery occurred during the administration of the potassic iodide and mercury; but the history of hereditary syphilis is too meagre to warrant conclusions.—*Rep.*] *Obs. of Gr. Brit. and Ireland. Amer. Supplement, Nov., 1877, p. 124.*

**Condition of the eyes and teeth in hereditary syphilis.** MR. HUTCHINSON, in his paper read before the Pathological Society, March 2d, 1875, points out the frequent co-existence of lamellar cataract, and an imperfect development of the enamel of the teeth, concluding that the exhibition of mercury during

infancy, and the occurrence of convulsions, are the two most important factors, etiologically. He declares that there is no reason whatever for supposing that lamellar cataracts have any connection with hereditary syphilis, but that the mercury given to syphilitic children is a common cause of mercurial teeth. The distinction between the latter and syphilitic teeth is important, and readily made, though the two conditions, as might be expected, frequently co-exist. *Brit. Med. Jour., Mar. 6, 1875.*

**Ophthalmia in hereditary syphilis.** MR. WALTON, after expressing his belief in the possibility of intra-uterine transmission of syphilis (foetus to mother and the reverse), exhibited one male and two female patients, aged respectively eighteen, sixteen, and fourteen years, affected with ophthalmia, induced by hereditary syphilis. The symptoms in the three cases were similar, sclerotic redness, iritic adhesions, haziness of the vitreous body, and corneal opacity. All had Hutchinson's teeth, and were improving under specific medication. *Med. Times and Gazette, Sept. 15, 1877, p. 300.*

**Deafness in hereditary syphilis.** DR. JONES remarks that, in many of the patients examined by him, deaf in consequence of hereditary syphilis, there is no abnormal pathognomonic appearance of the membrane, though at times it is greyish in color, opaque, thickened, and inflates with a dry click. There is nothing typical here. In the early stage much may be done by rapid mercurialization (inunction), iodide of potassium internally afterward, and injecting the tympanum with warm solutions of the same drug. Due attention should be given to the eustachian tube. But when there is extreme deafness to watch and tuning fork, characteristic teeth, and evidences of interstitial keratitis, recent or remote, treatment seems to be without avail.

[In this latter statement Dr. Jones merely reiterates the fact already established by Mr. Hutchinson.—*Rep.*] *Med. Press and Circular ; Med. and Surg. Reporter, Nov. 17, 1877, No. 1081, p. 392.*

**Deaf-mutism in hereditary syphilis.** DALBY declares that, next to scarlet fever, inherited syphilis may be considered as the most fruitful cause of deaf-mutism, as it occurs in children who are born with good hearing power, which is early and rapidly lost. It is the nervous, not the conducting, part of the auditory apparatus which is at fault, and the changes in the tympanum have no connection with the affection. To estimate clearly the value of treatment, the course of the disease is to be noted in children who have healthy tympana, and a condition of perfect health in the middle and external ear. With such, no known treatment is effective : sound vibrations, conveyed through the cranial bones, produce no impression.

Teeth and corneal changes usually co-exist. The most usual date of the occurrence of deafness is early childhood (after they have begun to talk), or the period between this and puberty. One case was observed with deafness beginning in the 23d year. It may be roughly said, that if adult life is reached with good hearing, these subjects do not become deaf from the same causes which produce this symptom in earlier life. It has not yet been determined whether the seat of the lesion, which impairs the functions of the auditory nerve, is in the labyrinth, or in the nerve, before its termination in that structure. *Lancet*, Feb. 10, 1877; *Half Yearly Comp. Med. Sci.*, Part XX., July, 1877, p. 641.

**Intra-uterine eye disease in hereditary syphilis.** DR. BULL, recognizing the fact that gummata and visceral lesions are often discovered in prematurely born, hereditarily syphilitic infants, believes that intra-uterine ocular disease in such infants is not so uncommon as is generally believed. The rarity of such disorders depends, he concludes, upon the tendency to revert to a healthy type; upon the frequency with which one parent is found to be exempt from infection, upon the character of the parental disease at the moment of conception, and upon the enjoyment by the fœtus of the benefit of the treatment of the progenitors. He has seen three cases of "purely congenital" iritis, two of which exhibited evidences of choroiditis, though Förster regards this symptom as a result only of acquired disease in its later secondary, or early tertiary form.

The author also expresses his disbelief in the frequent concurrence of interstitial keratitis, and the dental changes described by Hutchinson, calling attention to the non-acceptance of the views of the English school on the continent of Europe—[a dissent, by the way, which one European writer has lately emphasized by a rather formidable list of recognized authorities.—*Rep.*]

Dr. Bull continues by recognizing what he terms the "miscibility of syphilis with scrofula" and tuberculosis, each disease requiring treatment, and concludes his paper with the brief history of four interesting cases. *Amer. Jour. of the Med. Sci.*, July, 1877, p. 66.

**Disease of the umbilical cord in hereditary syphilis.** DR. TAYLOR, (J. M.) of New York, communicates the details of a case, in which a lady had suffered from seven abortions, at from the third to the eighth month, without appreciable cause. In one instance, a seven or eight month fœtus had evidently been dead for several days, and there was an indurated umbilical cord, transverse section of which showed three, solid, quill-like tubes, enveloped in a common sheath of condensed and reddened cellular tissue. It was discovered that the husband had had pre-marital sore of the penis, whereupon mercury and iodide of potassium were administered to the mother, and she bore a child which lived to the

third month, dying of disease of the respiratory organs. The succeeding pregnancy, under medication, resulted in the birth of a child, dying at the second week.

[It will be seen that the details are too loosely reported to admit of deductions which might prove of value—*Rep.*] *Ohio Med. Recorder*, Sept. 1877, p. 162.

**Disease of the testicles in inherited syphilis.** Of the seven patients observed by HENOCH, four exhibited lesions of both testes: three of the left only. The children were from three months to two and a half years old. The author also observed four cases of tuberculosis of the testis, in which there was firm induration, strictly limited to the epididymis and associated with lesions of a similar character in the lungs and cheesy degeneration of the bones, symptoms of syphilitic infection being excluded. In one case, which resulted fatally in consequence of diarrhœa, there was interstitial hypertrophy of the connective tissue of the mediastinum testis. *Deut. Zeitschr. f. prakt. Med.* No. 11, 1877.

**Destructive bone disease in hereditary syphilis.** MACNAMARA'S clinical lecture was founded upon the case of a girl, aged 18 years, whose father had displayed syphilitic symptoms before her birth. She had characteristic incisor teeth, expanded and broken bridge of the nose and imperfectly developed intellect, with clearly defined mitral disease. The lower end of the shaft of the left tibia and fibula, was surrounded, about one inch and a half above the ankle-joint, by a permanent swelling, extending around the entire circumference of the bones, very suggestive of the disease known as "ring-bone" in a horse. The skin and soft tissues in the neighborhood were natural in appearance although indented, the ankle-joint unaffected. The part was both painful and tender.

Treatment in hospital procured no relief. Finally effusion occurred in the joint, and a full-sized drainage tube was inserted, the result being supervention of septicæmia and amputation of the limb three inches above the ankle.

[We fail to find in the history of the case as reported, any explanation of the reasons which induced the colleague of the lecturer to resort to the unusual procedure of inserting a drainage tube into the ankle of a patient affected with syphilitic disease of the bones seated one inch and a half above the joint.—*Rep.*] *Lancet*, *Am. Reprint*, Jan. 1878, p. 12.

**Multiple fracture of bones in congenital syphilis.** M. POLAILLON offered some explanatory remarks, before the Société de Chirurgie, relative to a case recently reported by Porak. A primipara, who had exhibited a syphilitic eruption in the second month of her pregnancy was delivered of a male infant presenting by the breech. It weighed three kilogrammes; and on the following day, the humerus of each arm was found to be fractured.

The child was fleshy and exhibited no trace of syphilis. For a few days it seemed to thrive, taking the breast well, but afterward assumed a yellow tint, was affected with diarrhœa, ceased to seize the nipple and died on the eighth day. *Post-mortem*, all the bones were found diseased and a large number of them fractured.

This is the fourth case of the kind published; and the reporter called attention to the interesting medico-legal feature of the history, showing the necessity of excluding syphilis in case of alleged obstetrical malpractice. *La France Méd. Nov. 4, 1877, p. 701.*

### **Hereditary syphilis of the naso-pharyngeal region.**

CHABOUX concludes that late tertiary syphilis, particularly the hereditary form in children and adults, is far more common than is generally supposed; that the naso-pharyngeal region is its site of election; that suppurative osteitis of the nasal and palatine bones with ulceration of the velum, isthmus and pharynx, as well as certain forms of tubercular lupus, limited to the alæ nasi and septum, should not be too hastily attributed to struma; and that anti-syphilitic treatment, without rejecting the possibility of a strumous origin and of the value of remedies directed to the scrofulosis, should be employed if such other remedies prove of no avail.

(*Certain lesions of the Naso-Pharyngeal region, which should be attributed to syphilis. Thèse de Paris, 1875, Delahaye, Paris.*)

**Dactylitis syphilitica.** MR. H. CRIPPS LAWRENCE, reports the history of a two weeks old male infant, in whose case the distal end of the first phalanges of the right fore and middle fingers respectively, were considerably swollen, and covered with tense bluish integument. The first phalanx of the third right toe was in a similar condition. The sternal end of the right clavicle was also enlarged. Chestnut-sized swellings were found in the left pectoralis major and biceps humeri muscles. The child improved under specific treatment. *British Med. Jour., Dec. 1, 1877, p. 768.*

**Epiphyseal disease in inherited syphilis.** MR. HAWARD exhibited specimens, in which the disease could be traced from simple hyperæmia to complete epiphyseal separation, taken from the body of an infant with a distinctly syphilitic history. By the tenth week it had lost the use of its right arm, and when first seen by the reporter, both upper limbs were powerless. Death occurred from bronchitis, and, *post-mortem*, this disease was found to be the chief visceral disorder. Around the lower end of each humerus was a collection of laudable pus, and, while the synovial membrane was not diseased, the epiphyses of the bones belonging to the joint were separated by granulation tissue and pus.

Mr. Haward dwelt upon the frequency of the disease, the fact of the pseudo-paralysis by which it was accompanied, and its characterization, in its early stage, by swelling limited to the epiphysal line. It usually yielded readily to mercurial treatment, ought not to be mistaken for rickets, and might be the only evidence of in-

fantile syphilis. *Path. Soc. of London ; Med. Times and Gazette, June 9, 1877, No. 1406, p. 626 ; Lancet, May 5, 1877, p. 646.*

**Bone disease in hereditary syphilis.** DRON exhibited to the Society of Medical Sciences at Lyons, the femur of an infant affected with hereditary syphilis. There were new layers of osseous formation between the bone and the periosteum. Here and there, needle-like, minute implantations were to be seen at right angles to the axis of the diaphysis. The cartilage adjacent to the epiphysis, was as soft as the crystalline lens ; and presented at various points yellow patches of fatty degeneration. The reporter considered this to be the first stage of the affection, one which would have later resulted in a gelatiniform degeneration of the neoplastic tissue, until, the cartilage having no longer the consistency requisite to unite the diaphysis and epiphysis, false joint would have resulted.

In response to the inevitable question by Fochier, as to how these were to be distinguished from rachitic lesions, Dron replied that the syphilitic affection involved only the extremities of the bone, the central portion, which yields so readily in rickets, remaining solid. Poncet thereupon remarked that no reliance could be placed upon this central solidarity, as he had examined rachitic bones which, at certain points, possessed an abnormal power of resistance. Dron concluded by remarking that at the Antiquaille these little patients usually succumbed to hypostatic pneumonia, treatment proving unavailing. *Lyon Médical, June 17, 1877, p. 223.*

**Cranial alterations in inherited syphilis.** An editorial of the *British Medical Journal* is based upon the communication made by Parrot to the French Association for the Advancement of Science, during its recent meeting at Havre. Parrot there definitely announced that the pathological deformities of the cranium, produced by hereditary syphilis, were frequent and characteristic, though rarely recognized, the disease involving the connective tissue, and more particularly the osseous system, into the structure of which connective tissue enters so largely. The bones may be affected separately or conjointly with other organs. The lesions are so characteristic that they suffice at once to establish the fact of hereditary syphilis in the subject to whom the bones belonged. They consist in ulcerations or osteophytes, the latter alone being interesting, as regards cranial deformities. The location, appearance and structure are distinct. They occur in the form of more or less large and thick lenticular plates on the cranial surface, in the peribregmatic angles of the frontal and parietal bones. Thence they may extend to other parts of the vault of the skull, excepting always the frontal and parietal protuberances. During the progress of the disease the parts first invaded became considerably thickened, and, finally, two tuberosities are seen along the coronal suture, and two others on the parietal bones, bordering the sagittal

suture. These elevations are separated from each other by deep grooves; whence result a form and appearance of the skull truly typical, and which only hereditary syphilis can produce. The elevated portions are distinguishable from the rest of the healthy bone by the existence of pores on the surface, by vascular grooves, and by their structure, for they are formed by osseous tubercular and medullary spaces, perpendicular to the surface of the normal bone. The histological characters differ essentially from those of healthy bone. Often, by the extension of osteophytic layers to the sutures, these are prematurely united, and thus, not only an arrest in the development of the cranial cavity may be caused, but also that of the brain itself. These cranial marks of hereditary syphilis are indelible.

The skull of a young Indian of Pernambuco, two skulls of children, presented to the Institute of Anthropology by Destruges (procured at Guayaquil from the sepulchres of a period anterior to the arrival of the Spaniards in the New World), and ten skulls of adults, one from Africa, and one from Lima, in the collection of the museum, were all found to display the typical deformities of ancient hereditary syphilis. Parrot hence concluded: 1. That hereditary syphilis deforms the skull in a typical and indelible manner. 2. That syphilis existed in Peru and Guayaquil before the discovery of America. The discussion of the paper was conducted by Messrs. Lunier, de Quatrefages, Bertillon, Jourdanet, Broca, Gibert and Lagneau, and, as a rule, their observations seemed to confirm the views of the reader. Dr. Gibert, of Havre, who had treated more than fifteen hundred syphilitic children, could not, however, see how it was possible to distinguish the lesions of hereditary syphilis from those of rickets, and laid stress upon the fact that it was formerly admitted that the characteristic lesions of the disease were visceral.

The conclusions of the editor are as follows: "Either M. Parrot has discovered a scientific mare's nest, or he has made an extremely interesting and important contribution to pathology and diagnosis."

[Those who have made themselves acquainted with the careful and elaborate researches conducted by Parrot for the past five years, and the results which, from time to time, he has made public in his communications, will not question the scientific accuracy of his conclusions.—*Rep.*] *Brit. Med. Jour.*, Oct. 13, 1877, p. 530.

**Brain atrophy in hereditary syphilis.** Specimens were exhibited by DR. BARLOW, taken from the body of a fifteen months-old infant, with a doubtful syphilitic history. There had been emaciation, left strabismus, slight but intermittent nystagmus, pupils equal, and no morbid ophthalmoscopic signs. The facial muscles were slightly affected—there was less frown on the left than on the right forehead. The left cheek was flat

on crying, and very slight tremors of the muscles of both sides were perceptible. The condition of the other cranial nerves was doubtful. Laryngeal spasms occasionally occurred, and vomiting, probably associated with gastro-enteric disturbance. There were no general convulsions. The diagnosis was made of tumor, at the base of the brain, probably tubercular. *Post-mortem*, no tubercle was found. The liver contained four cicatricial patches, but it was not puckered, the growth being almost purely cellular. The spleen presented some old disease of the capsule. The principal changes were found in the brain, which was atrophied as a whole. The membranes of the base were slightly opaque, and several of their nerves presented distinct swellings at the point of their superficial origin—perfectly symmetrical. Microscopically, the nerves presented almost complete atrophy of the cylinders, a new growth irregularly distributed, and corpora amylacea in some places. These growths, which might be called “nerve gummata,” somewhat resembled to the naked eye the changes found in the nerves in anæsthetic leprosy, but in the latter, the process affected the interfunicular tissue, rather than the cylinders. With respect to the cerebral blood vessels, all the basic arteries were found to be thick, opaque, and of increased firmness, without either gummata, special dilatation or calcification. On section they presented an irregularly diminished lumen. Both the adventitia and muscularis were found diseased under the microscope, the chief thickening being situated in the intima, while the endothelium was healthy. The arteries of the second order were almost free from change.

Mr. Spencer Watson remarked that he had recently observed a case of nystagmus in a syphilitic child, which was greatly benefited by mercury. In such cases the choroid might be the seat of disease. *Lancet*, May 5, 1877, p. 645.

**Chorea in subjects of congenital syphilis.** A correspondent of the *Philadelphia Medical Times* describes the case of two patients—a seven year old boy, with unilateral chorea and the teeth of congenital syphilis, and his twelve year old sister, suffering from a severe form of bilateral chorea. Neither improved until a mercurial was added to the general treatment, the writer showing that syphilis exerts a power over intercurrent disease, which must be recognized and antagonized before the therapy can be successful. *Phil. Med. Times*, Sept. 14, 1877, p. 326.

**Syphilitic chorea.** Of DR. ALISON'S four cases, the first was a seven year old girl, who, it is said, contracted syphilis by nursing from the nipples of her mother, and died of hemi-chorea. [The last named disease is said to have resulted from the syphilitic dyscrasia, but inasmuch as the diagnosis rests upon the statement of the mother that the child had a “distinct rash,” and, so far as the record informs us, upon no other basis, it can only be accept-



ed with reserve in the absence of necroscopic details.—*Rep.*] *Amer. Jour. of the Med. Sci.*, July 1877, p. 75.

**Hepatic enlargement in inherited syphilis.** At a meeting of the Pathological Society of London, held on the 6th of February, 1877, Mr. HUTCHINSON described a form of hepatic enlargement in hereditary syphilis, which, in his opinion, did not result from gummata, but was due to mere vascular turgescence, in consequence of some obscure disease of the nervous system. He cited the case of a lad whose mother, as well as several brothers and sisters, had suffered severely from syphilis, and whose liver on occasions "hung below his navel." *Post-mortem*, the viscus was found normal, with the exception of a few patches of thickening upon the capsule.

Apropos of this, DR. BYRON BRAMWELL narrates the case of a twelve-year old boy, small and delicate in appearance, with an inguinal cicatrix, square forehead, pegged teeth, and shrunken nose. Hepatic and splenic enlargement was clearly established; and improvement was speedy under appropriate treatment. *Med. Times and Gazette*, Dec. 22, 1877, p. 670.

**Late lesions of inherited syphilis.** KLINK reports the case of a nineteen-year old male, who, one year prior to examination, noticed a small painless tubercle upon the right side of his nose, which in three months had enlarged to the size of a hazel-nut, and subsequently degenerated, in spite of local treatment, till an ulcer formed which extended and deepened. Some weeks after the appearance of this tubercle, papules developed upon the skin of the face, alæ nasi and upper lip, which also degenerated and finally united in forming a single ulcer of enlarging area. Meantime an offensive ozæna occurred. There was no early history of disease, though the patient looked to be no more than twelve years old. The father was said to have suffered from recurrent eruptions and ulcers.

Dull red infiltration of the skin of the forehead and cheeks in the neighborhood of the nose, gradually shaded into the normal color of the sound tissue, where occasionally doughy spots could be felt; while a few flattened papules could be seen here and there upon the border line between the affected and non-affected tissues.

Radiate cicatricial tissue extended to the upper lip and the nasal integument; the nasal cartilages and septum were completely destroyed. On the skin of the forehead, near the root of the nose, was an ulcer  $1\frac{1}{2}$  ctm. in length, covered with a thick brown crust. On the right side, the tissue of both the upper and lower lips was affected. There was a white scar over the right temporal region. The right superior canine tooth was movable, and the other notched and of a dirty color. The gums were swollen and ulcerated. Upon the right side of the chin was an ulcer 3 ctm. in length and one in breadth, also covered with a thick brown crust. It had evidently been larger at one time, as its borders were sur-

rounded by a reddened cicatrix. The upper half of the right radius and the entire left tibia were thickened but painless on pressure. Cervical adenopathy existed on the right side.

Under specific treatment for two months and a half, the ulcers healed and the general condition improved. *Medycyna T. iv, No. 33, 1876. Viertel. f. Derm. u. Syph., Heft. 3, p. 417.*

**Very late skin lesions in hereditary syphilis.** DR. BULKLEY reported at the First Annual Meeting of the American Dermatological Association, the cases of two females, aged respectively, twenty-three and twenty-four years. In the former an ulcerative degeneration of a growing tumor, had appeared within one year; in the latter, there had been recurrent, almost continual, tubercular eruptions since the seventh year. In the first case the history of maternal syphilis was complete, and the patient showed Hutchinson's changes in the teeth; the disease had certainly not been acquired, and the lesions were yielding to specific treatment.

Dr. Taylor had seen several cases of late hereditary syphilis but was skeptical respecting skin lesions occurring after twenty years of age, when the skin, as a rule, enjoyed immunity, and bone lesions predominated.

Dr. White, referring to the dental lesions, remarked that he knew of the case of a boy who presented the central incisors notched from side to side and the lateral incisors wanting, where the suspicion of syphilis was absolutely excluded. The other teeth were normal. The deformity succeeded a sudden and severe attack of cervical adenopathy. *N. Y. Medical Record, Sept. 29, 1877, Whole No. 360, p. 622. Archives of Dermatology, April 1878.*

**On the inheritance of syphilis.** DR. McCLINTOCK, in his paper, expresses his belief in the transmissibility of syphilis to the fœtus from the mother who is infected after conception; and upon this basis reposes the doctrine that a medicament, administered to the pregnant woman, may affect her unborn child. [With singular inconsistency, he cites in illustration a case reported by Dr. Thorburn, in the latter's *Medicinal Treatment of the Unborn Child*, where a mother, whose husband and children were syphilitic, never had any detectable symptom of the disease.—*Rep.*] *Brit. Med. Jour., Oct. 13, 1877, p. 513.*

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## Reviews and Book Notices.

*Atlas of Skin Diseases. Part III. Eczema (Squamosum), Syphiloderm (erythematosum), Purpura (simplex), Syphiloderm (papulosum et pustulosum).* By Louis A. Duhring, M. D. Philadelphia: J. B. Lippincott & Co., 1878.

The third part of this excellent atlas compares very favorably with those which have preceded, and fully bears out the hopes and expectations which we expressed when calling attention to Parts I and II. The real value of these plates can be appreciated in no way better than by comparing them with other representations of cutaneous disease, for, while no pictorial delineations of skin diseases can fully satisfy the eye, or take the place of clinical study, we think that Dr. Duhring has succeeded in representing these affections in a manner satisfactory to the profession and creditable to the highest degree.

The first plate, of squamous eczema, represents a large number of the cases of this polymorphous disease: the indistinctly mottled surface and illy defined borders are very characteristic. This effect however is obtained only when the plate is looked at from a little distance, and when stood up three or four feet off, the total appearance afforded may be truly said to be perfect. Skin lesions require to be observed both from a little distance and also very near to, in the first we get a general grasp of the entire eruption, which is lost when close by, while, by minutely studying the single lesions of an eruption much may be learned both diagnostically and therapeutically. With plates of the skin, however, the second mode of study is rarely, if ever, applicable, for the surface being level the lights and shades are produced by colorings which do not appear on the living skin. In the study, therefore, of these excellent representations by Dr. Duhring, a much clearer idea of the disease is obtained if they are placed in a good light and viewed from a distance of nearly twice the arm's length.

The second plate of the erythematous or macular syphiloderm is by far the most truthful which has ever appeared in any atlas.

In the third plate, representing purpura, one could wish that some of the stainings left after the hemorrhages were shown. But as they did not exist in this case, this being the first attack, they do not appear in the plate, in this instance the full value of the plate is sacrificed in this to its absolute truthfulness as representing the case described.

The representation of the papular and pustular syphiloderm in Plate IV may not strike some as very good, at first sight. But careful study shows its excellencies, and as compared with other representations of the same eruption it is most excellent. It is a marvel of lithographic work, in the perfection with which the "collarettes" are exhibited; the exceeding difficulty of such exact work can hardly be appreciated.

The succeeding parts are promised with more punctuality, and when the work is completed it will be one of which American Dermatology may well be proud.

“Brevity, indeed, upon some occasions, is real excellence.”

—CICERO, BRUT. 13.50.

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# ARCHIVES OF DERMATOLOGY.

JULY, 1878.

Original Communications.

## ON THE USE OF THE SOLID RUBBER BANDAGE IN THE TREATMENT OF ECZEMA AND ULCERS OF THE LEG.\*

BY L. DUNCAN BULKLEY, A. M., M. D.

*Physician to the Skin Department, Demilt Dispensary, New York; Attending Physician to the New York Hospital Out-Patient Department for Skin and Venereal Diseases, etc.*

**F**EW cases of chronic affections of the skin are more distressing to the patient and annoying to the physician than those of eczema and ulcer of the leg which are dependent upon varicosity of the veins; and it is the fact these cases occur in those who are least able to rest, and to put themselves in a condition for recovery that makes them more rebellious to treatment. Every one can recall cases of chronic eczema of the legs (often erroneously called erysipelas), and of ulcers, which, either they have treated for a time with moderate success only, until the patient was tired of treatment, or else in which they have simply advised the wearing of a bandage, or a laced—or elastic—stocking, hardly expecting more than a palliation of the troublesome symptoms. My mind runs back, during the past few years, to many, many such cases in Dispensary practice, when relief has been given time after time, only to be again sought for when some unusual amount of standing or exhaustion has occasioned the old enemy to break out anew: And these cases often occur in hard-worked house-wives, the mothers of large families, whose very

\* Read before the New Hampshire Medical Society, June 19, 1878.

existence depends upon their being on their feet all the day, like as not at the tubs or ironing table; the same is seen in men or women who stand continuously as cooks, waiters, factory hands, etc. And these cases are also very commonly seen in those in whom poverty has also had its share in producing the lesion, and scanty and poor food has so relaxed the tissues that the veins easily become distended, and the capillaries readily dilate and rupture.

Now to attempt to put such patients in bed is utterly out of the question, and even when it is possible it is well known that the results of treatment in bed are often temporary, and that when the patient resumes the standing position the eczema or ulcer may and frequently does return.

If an ordinary bandage, or an elastic- or a laced-stocking is used to keep the disease in check, we have the constant distress and aggravation of the trouble occasioned by the sticking of the dressing to them, or to cloths placed beneath them, while the firm, non-elastic tension of the cotton bandage and the laced-stocking is often really distressing to the patient: the cost of elastic web stockings and the necessity of their frequent renewal is a serious obstacle to their use in very many cases.

For these reasons the solid rubber bandages promises, I think, to effect a revolution in the treatment of such cases, and will be hailed with pleasure by multitudes of physicians and patients.

One year ago Dr. H. A. Martin, of Boston, brought the subject before the notice of the American Medical Association,<sup>†</sup> and his claims for the solid rubber bandage were so extraordinary that I determined to make use of it on the first opportunity, feeling assured that this was just the means I had long wanted for the cure of a certain class of my patients whom I felt certain were not receiving all the relief which medical skill should furnish them. The article fell under my notice some months after it was delivered before the Association, so that my time for testing the matter has been somewhat limited, (shortened also by sickness and consequent absence from work and from the city), and the actual number of my cases is small compared with the several hundred cases in which Dr. Martin has employed it.

But the subject has appeared to me to be of such vast importance, and my results with this method of treatment have been so uniformly good, as have also those obtained by others to whom I have recommended it, that I feel it my duty to again present the subject, somewhat modified, and to urge with all my powers the immediate attention of the profession to this new and exceedingly valuable addition to our therapeutical resources in the management of some of the worst cases which can distress both patient and physician. Not claiming originality in the matter, I shall consider myself free to use Dr. Martin's valuable paper as best I may in developing

<sup>†</sup> *Chicago Med. Journal*, October, 1877; *Transact. Am. Med. Asso.* Vol. 28, page 589.

the subject and impressing it upon my hearers ; and, as my experience has been identical with his, I shall of necessity refer to many of the points to which he calls attention, and shall not always refer to him, but here give him all credit for his work, and advise my hearers to read or re-read his paper in connection with this. He treats of the use of the bandage in ulcers and varicose conditions of the leg, also in certain surgical aspects of diseases and injuries of the joints, etc., but does not mention eczema, although he alludes to having used the bandage in some cutaneous affections of the legs, "to which" he says, "very learned words of sesquipedalic length are applied in the jargon of dermatology," "that great science of words," as he styles it in another place.

My practice being confined to diseases of the skin I purpose to give you my experience in the use of this measure in eczema and ulcers of the leg, as it is only in these lesions that I have myself employed it ; I will afterwards briefly allude to other conditions in which it has been or may be successfully used. I will very briefly mention the cases, because more impression is thus made than if simply the results of treatment are stated in a general manner.

CASE I. *Long standing eczema of the leg with great induration.* The most striking case perhaps, was the first one to which I applied the bandage, and as this patient has been the longest under observation, both before and since its application, it is perhaps to me the most instructive and valuable of all.

Mrs. E. F., a large and rather fleshy woman of 45 years, applied for treatment at Demilt Dispensary, in February, 1877. She then had well marked tubercular syphilis about the nose and upper lip, with many cicatrices from the same on the forehead and elsewhere. Her right leg presented a most distressing state of disease, which had existed more or less severely for over nineteen years. It was enlarged from the knee down to, and including the ankle, so as to be twice the size of the other ; was hard with the thickening of the skin ; its surface exhibited a raw and exuding eczema to nearly its entire extent ; and there were numerous ulcers, especially about the ankle, with hard, sharply-cut edges and indolent bases. The leg itched intensely and she scratched it more or less ; it also gave her almost constant pain while standing, which she was obliged to do continually, washing and caring for the family. Some of the ulcerations of the leg had very much the appearance of those of tubercular syphilis, and I had great hopes that the treatment for that disease would also be of much benefit to this portion of her body.

Not to enter too much at length into clinical details, suffice to say that she attended the Dispensary quite faithfully, and was treated assiduously until August ; but that the leg entirely refused to heal, although the syphilitic lesions on the face yielded to proper measures. This medication would often seem to make the eczematous element on the leg worse, and yet when the anti-

syphilitic was discontinued the tubercular eruption reappeared. Various local measures of approved kinds were also ineffective on the leg, owing, undoubtedly, to the insurmountable obstacle of her occupation.

On November 22d the rubber bandage was applied at the Dispensary, and the internal treatment for the syphilis was continued.

On December 4th she was exhibited before the gentlemen attending my clinic, and the note was made that the leg was better than it had been for nineteen years. The limb was then reduced at least one-half in size, and was hardly larger than the other; the entire surface was smooth and dry, and very red, the enlarged papillæ showing distinctly beneath the thin layer of epidermis; many of the ulcerations had healed: she experienced no pain or itching in it, and she had been on her feet all the time as before. There had been no local treatment employed of any kind, except the application of the elastic bandage, as will be described later.

In three weeks more the ulcers had healed, and the leg appeared as well as the other, except the red, glossy condition, which still remained. This patient has been under observation and treatment ever since, for her syphilis; the leg remains perfectly well, and although she still continues to wear the rubber bandage for the support it gives the limb, she has no signs of her former trouble; the leg is the same size as the other, every trace of the very great thickening is gone and, consequently, there is no itching or pain. Varicose veins seem to have played a very small if any part in this case.

CASE II. *Acute eczema accompanying ulceration of the leg.* This case is almost as striking: Mr. J. P. B., aged 41, a mercantile reporter, presented himself at my clinic at the Out-Patient Department of the New York Hospital, March 11th, 1878, for the treatment of eczema of the leg with numerous ulcerations, with the following history:—

Nine months previously he had had acute inflammatory rheumatism, affecting principally the ankles. This was followed by swelling of the leg, with enlarged veins and the appearance of several ulcers. For the ulcers he had been for six weeks laid up in the hospital, and as the ulcerations were in part healed, and his business prevented further confinement, he applied at my clinic for subsequent treatment. When first seen, the whole of the left leg was greatly enlarged from the knee down; about the ankle there was much œdema: the surface was red and glazy, much of it exuding copiously, and with a number of rather small ulcers in various situations. It was done up in lint, covered with a cotton bandage; he had on a large cloth shoe, and was quite disabled by the bulk of the limb, and the pain and itching. All the dressings were removed and a rubber bandage applied.

March 15, four days afterward, it was recorded that there was great improvement; very much of the swelling was gone; the leg was hardly three-quarters the previous size; many of the eczema-



tous spots and some of the smaller ulcers were healed. There was little or no itching and no pain. He had returned to his business immediately after the application of the bandage, and on the preceding day had walked six miles.

March 20. All the ulcerations but two are healed. No eczema remains; the leg is about the natural size and he walks all day with ease.

March 27. The leg is about as well as ever: he is now for the first time put under some constitutional treatment for eczema on the arms.

CASE III. *Severe chronic eczema rubrum of both legs and thighs; one only treated by bandage.* Mr. H. L., a large, rather corpulent gentleman, aged 56, seen in private practice, has had eczema of both legs, for a year and a half, gradually extending so as to cover the entire limbs, to the groins, during the past four months. He has been under approved treatment at the hands of a well-known New York physician during a considerable period, who finally referred him to me. He gives the history of having had eczema over much of the body during the first seven years of life. He has had asthma since a boy, until the last few years, when he has remained free from it. During the past year and a half he has been constipated, depending on the compound cathartic pills for movements from the bowels.

When first seen both legs, from the ankles to the groins were the seat of a red, exuding eczema, terribly itchy, and showing many signs of the results of scratching. Both legs were covered with cotton wadding and bandaged firmly, and he was in the habit of removing this two or three times a week, and washing the legs thoroughly, and coating them with camphorated vaseline. There was also more or less eczema upon the arms. He was treated in a general way with considerable relief to the itching, and on

May 23, the rubber bandage was applied to the right leg, from the toes to the groin, two twelve-foot, three-inch bandages being used.

May 25. To-day it is recorded that there is great improvement in the limb to which the rubber bandage was applied; all itching has ceased in it; when removed, the surface is red and shiny, but perfectly dry and with a moderately firm epidermis. The left limb, which was left in the cotton, still exudes, is itchy and has a considerable amount of scaly crusting upon it.

June 1. The right leg to which the bandage was applied is virtually well. At night when it is covered with cotton batting, there is no exudation and no itching. He longs to have the same applied to the left leg, which is still scaled and crusted, and at times intolerably itchy; formerly the right leg was the worse.

CASE IV. Cath. S., aged 65, applied at Demilt Dispensary, in November, 1877, with chronic eczema rubrum of the left leg, of two years duration. As she was obliged constantly to be on her feet, she was treated with but indifferent success.

Feb. 19. To-day a rubber bandage was applied.

Feb. 26. Leg very much better.

March 5. Still marked improvement. She did return after this date, and as she had paid for the bandage and it gave satisfaction we may believe that the ultimate result was good.

CASE V. Ellen C., aged 50, applied at Demilt on February 20th, 1878, with eczema rubrum of the right leg; she was treated with moderate success for a while.

March 2. A rubber bandage was applied and other treatment stopped.

March 16. The leg is much better, the swelling has disappeared, and the limb presents a smooth, moist, and slightly exuding surface, over which the enlarged papillæ are plainly evident. The patient expressed herself as much relieved; she has not been seen since.

CASE VI. George C., a fairly developed young man of light hair and delicate skin, aged 17 years, applied at the New York Hospital Out-Patient Department, May 3d, 1878, with an eczema of the right leg, the result of an injury two months previously. Under appropriate treatment there was considerable improvement, when on

May 20, the rubber bandage was applied and other treatment stopped.

May 24. Considerable improvement; much of the raw surface is healed, there being very little exudation when the limb is bared. The itching, which was previously considerable, ceases while the bandage is on. Several small ulcers which existed are healed, and there is some artificial eruption excited by the bandage, in the way of small, scattered, acutely inflamed, and very superficial pustules; for these he is ordered first to cover the limb with thin muslin, and then to apply the bandage.

May 27. Very considerable improvement; the acute irritation has disappeared and most of the eczema is well.

CASE VII. Thomas C., aged 56, a night-watchman, applied at Demilt, November 3d, 1877. The whole right leg was the seat of an eczema from the knee down, largely due to varicose veins, the result of his occupation, although there was also some eczema on the arms. After a short course of treatment with diachylon ointment and a cotton bandage, on November 24th, the rubber bandage was applied in the presence of the class, and all other treatment was discontinued.

Dec. 1. Very great improvement, much of the moist surface is smooth, dry and glossy; the itching has ceased: he has continued his occupation, and remains standing all night with ease.

Dec. 8. There is still very great improvement, and the surface is largely covered with healthy epidermis; there is no itching, and none of the aching pain from the varicose veins. The patient expresses himself in the highest terms as to the very great relief to all the symptoms afforded by the bandage. Three days after

this his wife came bringing the bandage, saying that the patient had met with an accident, breaking his thigh, and as he was removed to a hospital the bandage would not be needed.

CASE VIII. William McC., a laboring man aged 53 years, was first seen March 11th, 1877, at the Out Patient Department of the New York Hospital. He had a patch of chronic, thickened eczema, about four by two inches in diameter, over the middle of the left tibia: it had been of at least three months duration. A rubber bandage was applied without other treatment, and on

March 15th, it was recorded that there was great improvement in the appearance of the patch, and that the itching which had before been distressing had about ceased.

March 27. Still great improvement, the patch is nearly well. The treatment was ordered to be continued and the patient did not return.

CASE IX. Mrs. S., aged 53, a fleshy lady, who had always enjoyed excellent health, came to my office April 6th, 1878, with a patch of hard, thickened, rough, and dry eczema on the right instep; also with some eczema on the left foot and on the right forefinger. The patch on the right instep extended nearly around the ankle, and was nearly three inches in width; it itched excessively. She had had a similar eruption two years previously, and had been treated for the same by another practitioner with little benefit, from February to June, 1877.

She was given treatment suited to her case, and made slow but steady improvement.

May 18. The surface on the right ankle is now dry and scaly, and still gives much annoyance by the itching. The thickening does not yield to considerable stimulation, and a rubber bandage is applied from the toes to the knee.

May 25. The affected patch has improved greatly beneath the rubber, the itching ceased while it was on. Three days ago she left it off and the same day was greatly exposed to cold, riding a long distance; the following day she had a severe chill with high fever, and yesterday the upper part of the leg became hot and red in blotches, swollen and burning, and to-day there are large patches of congestion along the whole middle of the leg. She feared that this was caused by the bandage, but was assured to the contrary; the eruption did not at all resemble the very superficial eruption of minute pustules which the bandage sometimes occasions; it was probably due to the sudden and severe exposure of the leg to the cold, after the tissues had been relaxed by the profuse sweating which occurs beneath the rubber. She was ordered a cooling lotion of lead and opium, with elevation of the limb, and an alkaline diuretic.

May 28. The acute eruption has subsided, leaving the original patch much improved by the rubber treatment, though there is still redness and thickening.

June 17. To-day there is very much less thickening; there is

no itching while the bandage is on; but when removed at bed-time, the desire to scratch the part is still severe. For this she is directed to rub the diseased surface with the compound tincture of green soap, and to apply diachylon ointment during the night, carefully removing it wholly before replacing the bandage in the morning.

CASE X. Elizabeth O'H., aged 36 years, was first seen by me at Demilt, January 17th, 1878. She came for the treatment of large and painful ulcerations on the left leg, mainly about its middle and upper part, with the history of their having developed from a scratch received five months previously. The whole leg was the seat of a large, smooth, somewhat contracted cicatrix from a scald early in life.

Although there was considerable varicosity of the veins, the ulcers had so much the appearance of syphilis, that in spite of the absence of corroborative history, (which is so often wanting in women) she was placed upon an anti-syphilitic treatment, which was continued for over six weeks without producing any improvement in the sores.

At the end of this time an eczematous eruption developed spontaneously upon the right leg, which was also somewhat varicose, and on March 14th a rubber bandage was applied over the eczema; a mixture containing acetate of potassa was given, and the ulcerated left leg was still treated with a mild calomel ointment.

March 26. The itching of right leg has about ceased, and the condition is much improved; no change in left leg.

April 11. Still improvement in eczema; no other local treatment but the bandage.

April 26. The eczema is about well: bandage continued on account of the varicose veins.

June 15. The results of the treatment of the eczema were so good, that the patient had cut the bandage in two, in order to have the same applied over the ulcerated limb, and still to continue the support to the varicose veins in the right leg.

The two following cases of eczema treated in this manner, are furnished me by my friend, Dr. F. B. Lawson, who employed the bandages at my suggestion:

CASE XI. Mrs. A., German, aged 38, married, with seven children; besides attending to household duties, she stands many hours behind a lager-beer bar. She was found in bed, pulse 110, temperature 102°, complaining of great pain in right leg; bowels constipated, has headache and backache. The right leg below the knee was enormously swollen, hard and hot, and the whole surface red, or covered with thick crusts, a perfect type of eczema rubrum, with varicose veins.

The bowels were relaxed with compound cathartic pills; a diuretic was given, and the crusts were removed by means of repeated, cold flax-seed poultices; on the following day a rubber

bandage was applied from the toes to the knee, and a towel was directed to be kept wet with cold water over the bandage.

Three days later the patient was going about the house as usual, and said that her leg has not felt better for years; there was great reduction in the size of the leg, and the redness had almost disappeared. She applied the bandage herself with ease, washing the part every evening on removing it. Two small ulcers which existed near the internal malleolus were healing well.

Four days later she called at the office, the leg looking well and the ulcers healing.

May 1. Nine weeks later, the affected leg was about well, and a common roller bandage was ordered in place of the rubber one. The left leg was found to be swollen and tender about the ankle; a rubber bandage was applied, but it gave so much pain that it was removed and a thin layer of cotton interposed.

June 2. The right leg is quite well of the eczema, and the left was very comfortable until she left off the rubber bandage a few days ago, when it again become swollen and hot; she had been standing much. She is several months pregnant.

The very great severity of the case, and the very rapid yielding of the disease to the rubber bandage, even during pregnancy, are points of special interest.

CASE XII. Mrs. C., aged 63, a widow, who had had ten children, presented herself with an eczema of the right leg, especially marked near the ankle; it itches and burns, and at times discharges serum; there is a small ulcer over the malleolus. A rubber bandage was applied, with instructions to cleanse the leg and re-apply the bandage daily. She was not seen again for many weeks, when the affected leg was found to be entirely well. She said that the improvement had begun immediately on the application of the bandage.

CASE XIII. J. E., aged 38, was admitted to the New York Hospital, service of Dr. G. A. Peters, April 15th, 1878. He had had the femoral artery ligated two years previously for popliteal aneurism, and since that time has suffered from eczema of the leg. He was given a wash of bi-carbonate of soda, a drachm to the pint, to be applied on sheet-lint, and a rubber bandage over it.

At the end of three weeks he was discharged cured.

CASE XIV. The following case exhibits the value of this plan of treatment in chronic dermatitis, a state often closely resembling eczema, but due to local causes entirely. In this instance it was owing to the woman's occupation which necessitated her being all the time on her feet: Caroline McC., an English woman of 50 years, came to me at Demilt at the end of September, 1877. She had a considerable amount of varicose veins, and the whole right ankle was surrounded by a mass of inflamed and thickened skin, which made standing very painful. Some portions of the diseased skin showed immensely hypertrophied papillæ, which stood out separate, of a brilliant purple color, and which bled easily when

much irritated. The condition had lasted many, many years, and at times she was almost, if not quite, laid up with her sore foot.

She had long had treatment from many hands, and seeing that mild measures had always been futile, she was given a pretty strong caustic potash wash, with directions to rub and stimulate the parts excessively once a day, and then to cover them with a zinc ointment (3 j. ad 5 ss.) To accomplish this she promised to rest for a while. There was very considerable improvement following this plan of treatment, whenever resorted to, but as she got relief each time, she would then neglect the matter, and would return with the foot as bad as ever; she dreaded the pain of the caustic application, and begged for other treatment.

February 9. Rubber bandage applied from toes to knee.

February 23. The leg is very much better; the thickening has largely diminished, and with it the pain; the papillary prominences have about disappeared. She feels that she cannot do without the bandage.

May 7. The leg is all healed, and the thickening of tissue gone. She still has pain in it at times.

The following cases exhibit the value of this solid rubber bandage in ulcers of the leg:

CASE XV. *Very painful varicose ulcer of left leg.* Christopher O'H., a laborer, 53 years of age, applied at Demilt Dispensary, August 18th, 1877. He then had a varicose eczema of the posterior surface of the left leg, upon which an ulcer soon developed in spite of careful treatment, in consequence of his being on his feet continually. He attended quite faithfully, and at times the ulcer would almost heal, when his work would oblige him to neglect it, and it would become very much irritated.

February 29. The ulcer is very painful, about an inch in diameter, situated on the back of the calf on the lower half of the leg. He is confined to bed with it, and says he could not rise if the house were on fire. It bleeds very easily; the veins of the leg are considerably varicosed. A rubber bandage is applied from the toes to the knee while in bed.

February 23. To-day he presents himself before the class, and says that immediately after the application of the bandage he rose from bed, and has been up and around since, feeling perfectly comfortable. The ulcer bleeds as the bandage is removed. The day following the application of the bandage he walked several miles with perfect ease.

March 16. Ulcer healed; feels very well.

April 25. The leg remains well; patient is at work. He still wears the rubber bandage, and finds it a great comfort to the varicose veins.

CASE XVI. *Hard-edged varicose ulcers of right leg.* Lawrence G., a waiter-man, aged 57 years, came to the New York Hospital, Out-Patient Department, on March 3d, 1878, with very painful varicose ulcerations of the right leg. There were several indolent

ulcers, with hard, erected edges, and unhealthy bases. He was quite incapacitated from work, and had failed to find relief from various remedies. A rubber bandage was applied at once from the toes to the knees, no other dressing being used. He was directed to remove it in the evening in bed, to wash the leg and the ulcers with tepid water, and to leave it without dressing during the night. The bandage was to be cleansed, and hung up to dry, and to be put on again in the morning, before stepping out of bed. In the day time he is directed to walk considerably.

March 10. There is great improvement; healthy granulations fill the cavity, and much of the hardened edges have melted away.

March 25. The ulcers have cicatrized from the sides, and all of them are about well. There is but one very small spot, one-quarter by two-thirds of an inch in diameter on the ankle, yet unhealed.

The patient did not return, and as the progress had been so extremely satisfactory to him, it is fair to suppose that he became, and remains quite well.

CASE XVII. Michael G., a laborer, first came to me at Demilt Dispensary, October 9th, 1877, with a varicose ulcer on the back of the right leg. He was treated with the ordinary stimulating treatment, with varying results, the leg being better and worse, until March 12th, when a rubber bandage was applied, and he was instructed how to apply it himself every morning.

As he had been a faithful patient, and was a hard working man, it is fair to suppose that his failure to return was due to the perfect relief afforded by the bandage.

CASE XVIII. Peter C., a laborer, aged 53 years, applied at my clinic at Demilt, March 5th, 1878. He had an ulcer on the left leg, probably due to varicose veins, as it possessed all the features ordinarily seen in such. I may here remark that these lesions are exceedingly common among those of the poor of this city, whose occupations require them to be long upon their feet. He was treated with a balsam of Peru ointment (3 j ad 3 j), which produced some benefit for a while. On March 23d a rubber bandage was applied, and the patient shown how to re-apply it, with directions to wear it until well. As he was at work, he did not return to report results.

CASE XIX. James F., a clerk, aged 48, applied in the service of my colleague, Dr. Morris, as an out-patient at the New York Hospital, in August, 1877. He had varicose ulcers of the leg, which were treated by approved methods, with but indifferent success.

In March Dr. Morris applied the rubber bandage, and in a few weeks the ulcerations had entirely healed, no other treatment being employed.

The following cases, occurring in the New York Hospital, in the service of Dr. Geo. A. Peters, are kindly furnished me, with his permission, by the house surgeon, Dr. S. S. Kahn.

CASE XX. G. H., aged 37, was admitted April 15, 1878, with a varicose ulcer of the leg, four by two inches, which had existed for two years. It was treated by strapping and stimulating ointment for two weeks, with no improvement. A rubber bandage was then applied, and changed every second day. Cicatrization took place very rapidly, and in seventeen days he was discharged cured.

CASE XXI. *Ulcer after severe laceration of leg.* F. M., aged 8 years, received a lacerated wound of the leg, eight inches long, from being run over; the muscles were torn, and the bone exposed. The wound was under the Lister treatment for fourteen days, when there resulted a granulating ulcer, eight by two inches in size. A rubber bandage was applied, and in three weeks it had cicatrized up to two and a half inches by one-half inch, and is progressing very rapidly at the time of this report.

CASE XXII. *Ulceration of the foot after severe laceration.* R. D., aged 40, was admitted on March 2d, with a contused and lacerated wound of the dorsum of the foot, with compound fracture of the toe. When the slough separated, the anterior half of the dorsum of the foot was gone. The resulting ulceration was treated with usual measures until April 15, when it was about one-half its original size, but it had stopped healing, the edges became indurated, and the base indolent. Active stimulation failed to produce any effect; actual cautery failed to induce repair, and no change took place in it, until on May 15th a rubber bandage was applied.

June 3. The ulceration has made rapid progress in healing since the application of the bandage, and to-day there is a small, healthy, level, granulating surface, one-fifth the size of the original ulcer, which is healing very rapidly.

CASE XXIII. *Abscess over ankle.* J. L., aged 38, was admitted to the New York Hospital April 15, 1878, with an abscess of the ankle, which had opened spontaneously prior to admission. There was found a small opening from which sinuses ran in different directions; everything appeared sluggish. He was treated by astringent injections, and an ordinary bandage for six days, with little or no change.

A rubber bandage was then applied, and in six days more he was discharged cured.

CASE XXIV. *Ulcerations from burn of arm and forearm.* J. S., aged 42, was admitted December 20, 1877, with extensive burns of the face, back, neck, both arms and right ankle, received at the Barclay Street explosion and fire. After the immediate effects of the burn had passed off, including an erysipelas on the sixth day, the resulting ulcerations were treated by strapping, with frequent applications of nitrate of silver, and repeated skin graftings. Some of these latter took, but at the end of three months after the accident there was still a very extensive ulceration of the right arm, which progressed very slowly towards recovery.



March 24. The ulceration on the right arm extends from the wrist to two inches above the elbow, involving the entire anterior surface, and at the middle of the forearm reaching entirely around the member. A rubber bandage was applied over the whole forearm.

April 14. The ulcerated surface is becoming less; he is discharged, and made an out-patient, returning every second day; still to wear the bandage.

May 20. There are now but four or five ulcers left on the surface of the forearm, an inch and a half in diameter; the bandage to be continued.

CASE XXV. *Enormous ulcerations of arms after a burn.* G. H., aged 17, another victim of the Barclay Street disaster, was admitted December 20th, 1877. He was frightfully burned, much the same as the last patient, and was treated similarly for three months, with the result of having both arms covered with granulating surfaces, which refused to heal.

March 22. Rubber bandages are applied to both arms, which are the seat of enormous masses of exuberant granulations.

May 27. The healing has progressed rapidly and steadily, and now on the right forearm are only two spots of ulcerative surface, two inches in diameter, very healthy looking, and on the left arm there are also two ulcers, each about an inch in diameter. The granulations are level with the surface, and cicatrization is progressing well. The patient is still in the hospital.

CASE XXVI. *Ulcerations from a scald of thigh and leg.* R. S., aged 27, was admitted December 22, 1877, suffering from an extensive scald from escaping steam. The entire outer side of thigh and leg and ankle were implicated. On the separation of the slough at the end of a week, there was an ulcerating surface down the whole extent, to the breadth of four to five inches. It was strapped from January 12th to March 22d; grafted freely (about 40 grafts took); burned with nitrate of silver, etc.; and at the last date there was still a mass of exuberent granulations over almost the entire extent, which refused to heal.

March 22. Rubber bandages are applied from the foot to the groin.

May 20. The progress of cicatrization has been very rapid beneath the rubber; the improvement could be seen daily. By the end of a week the granulations were on a level with the skin. There is now but a single spot of ulceration on the thigh, an inch and a half in diameter, and one of about the same size on the leg. The discharge was very profuse for the first few days, so that the bandage was re-adjusted several times daily; this gradually diminished as the cicatrization progressed. The direction of the bandage was reversed every alternate day, to overcome irregularities in the granulations resulting from unequal pressure.

The contrast in the labor and expense of the dressing was very striking in this case. Before the use of the bandage about two

yards of adhesive plaster were consumed daily in each dressing; with the bandage no other measures were required.

- CASE XXVII. *Extensive and severe burns from nitric acid.* Edward D., aged 38, was admitted to the New York Hospital April 17, 1878. After the separation of the sloughs, rubber bandages were applied to the forearm and leg. The result up to June 3d has been a prevention of exuberant granulation, and a reduction of the size of the ulcerating surfaces about one-half their original dimensions. There were, however, some drawbacks
- in the case: sloughing took place unexpectedly over the crest of the tibia for about four inches. Although only moderate pressure was applied by the bandage, it was perhaps more than the weakened vitality of the tissues could bear. On the left forearm the bandage did well for a few days, when severe hemorrhage occurred twice beneath it, which finally required Paquelin's cautery before it was controlled.

In addition to the cases here detailed, I have employed the rubber bandage in other cases, and I have reports of its use in the Mount Sinai Hospital, where certain cases did excellently under it; they need not be given. The bandage has also rendered excellent service in the hands of several other of my professional friends. The cases here narrated are quite sufficient to illustrate the subject, and all the experience I have thus far obtained confirms in every respect the claims made for this method by Dr. Martin; claims which are so extraordinary as to possibly give rise to a doubt as to their truth in the minds of those who were not assured of the writer's veracity, and who applied neither reason nor experience to prove or disprove the facts.

A few remarks in regard to the details of this method of treatment may render the subject more clear to my hearers, and may perhaps assist some in employing it.

First, in regard to the bandages: they are made of the best, solid, pure rubber, and are very elastic. They are twelve feet long and three inches wide, as I have employed them, though they may, of course, be made of any desired dimensions.\* On one end a piece of cloth is cemented, an inch or so wide, to give firm attachment to the tapes which are to tie the free extremity. These tapes should, of course, be rolled inside, and the bandage prepared for application exactly as any other roller bandage. With a little care these bandages may be worn for a considerable length of time. In the first case I have given, the patient has worn one of Dr. Martin's bandages for more than six months,

\*The bandages I have employed are made by the Goodyear Rubber Curler Co., 729 Broadway, New York, and cost a dollar and a quarter each, for those of the dimensions given. Those employed by Dr. Martin are made of rubber twice as thick, and are of various widths and lengths. For those ten and a half feet long by three inches wide, I paid two dollars and a half each, or double the cost of mine. They may be obtained of T. Metcalf & Co., 39 Tremont Street, Boston, Mass.

and it is now as good as when first applied, with the exception of one slight tear. Dr. Martin has known a single one to be worn two, three, or four years, and has even cured several successive poor patients with the same bandage, which was yet perfectly serviceable. It is to be remembered, however, that grease or glycerine must not be applied at the same time, for they will soon destroy the elasticity and worth of the bandage. That this is not necessary will be seen from the history of the cases, and from what will follow.

Second, as to the cases to which it is applicable: I have treated of eczema principally because this disease comes under my notice more than any other. Dr. Martin laid more stress on the treatment of ulcers. I may remark then, first, in regard to the principles of treatment involved, that the *idea* of the rubber bandage is the protection and support of the tissues, and where these are indicated it will do good. Much of the eczema of the lower leg is associated with, and more or less dependent upon, a varicose condition of the veins, and it is generally this element which makes the disease so rebellious to ordinary measures; and even where the veins are not distinctly enlarged, still the natural condition of eczema is one of capillary enlargement, and the gentle compression of the bandage remedies this.

The rubber bandage, then, is applicable to and serviceable in a large share of the cases of ordinary eczema, it being more especially valuable in chronic cases, such as ordinarily resist all measures commonly employed. I have put it on when there was an acute or sub-acute inflammatory condition, and again when there was simply the infiltrated tissue left after an eczema, with no inflammatory phenomena, and with equally good results, as the cases narrated show. The bandage may, and often does, for a short time, sometimes for a longer period, cause an eruption of its own, namely, a few scattered minute pustules, running their course rapidly; but this need not interfere with its employment. If it is annoying, a cotton bandage or piece of thin linen, well fitted, may be placed beneath the rubber, but as a rule this is not required, for this condition will cease of itself under the continued use of the bandage.

Not less serviceable, if indeed it is not more valuable, will this plan of treatment be found in that very large mass of cases which are now suffering from long standing, uncured, and that otherwise almost incurable condition of ulcer of the leg. To these the solid rubber bandage is of almost universal application, and of well nigh certain efficacy. Indeed, Dr. Martin states that of many hundred cases to which he has applied it during the last twenty-five years, "all, without exception, have been perfectly and absolutely cured." A strong statement, but one which my judgment and experience leads me to accept as true. In thus speaking, it is not affirmed that every case to which every practitioner may give a rubber bandage will be cured; but, with due

care, and a little experience in selecting the cases and applying the bandage, and with a proper instruction to the patient, and obedience to directions on his part, together with, at times, some other treatment which the individual case may demand, I believe that it will be possible for every one of my hearers to cure all of the cases which apply to them for relief. And this is a very important assertion when we remember the thousands of uncured cases now taking their weary journey through life, with that most distressing clog, an uncured ulcer of the leg. Those, of course, which are syphilitic in origin cannot be permanently cured thus, but even in these it is of considerable service.

In addition to these uses of the rubber bandage, it is useful in ordinary varicose veins, even where there is no skin lesion, and as it can be adjusted day by day to suit the condition of the parts, it is much more manageable and satisfactory to the patient than either the laced or elastic stocking, while its continual yielding and contraction render it far superior to the ordinary inelastic cotton or flannel bandage. At first patients will complain of the heat, and of the retained perspiration, but after a few days these will cease to give annoyance, and the comfort of the bandage will be appreciated.

Some of the cases I have given show the value of this method of treatment in ulcerations from other causes, as burns, etc., and the results in these cases are so striking as to leave no doubt of the very general applicability of this form of dressing, where protection, support and slight pressure are required.

I have not had opportunity of testing the rubber bandage in other conditions, but, as suggestions for those who may not have access to Dr. Martin's paper, I may mention the other uses to which he has put this method of treatment.

In injuries and diseases of the joints, particularly of the knee and ankle, it has been found especially serviceable. In ordinary sprains it gives the greatest relief, and the patient may with advantage take exercise, the rubber answering in place of the ruptured or strained ligaments.

In effusion into the synovial sacs Dr. M. has found the rubber bandage of the greatest service, also in distension of the bursæ mucosæ, as "house maid's knee." In this he has had perfect success in seven cases, the bandage being worn night and day for a month, the sac having been first thoroughly evacuated.

In œdema and anasarca of the limbs most perfect relief is afforded by this means. Dr. Martin has recently informed me that he has used this means with great service in phlebitis. Likewise in certain injuries of the bones, as in "green stick" fracture, the gentle, constant pressure of the elastic bandage over a splint has restored the normal condition.

In rheumatism and neuralgia about joints Dr. M. has found much benefit from the application of the rubber bandage, the warmth, moisture and pressure causing absorption of effused matter.

In regard to other conditions of the skin in which the rubber bandage might do well, I may mention psoriasis, exfoliative pemphigus, pityriasis rubra, xerosis, ichthyosis, lichen ruber, pruritus, true prurigo, elephantiasis Arabum, etc.

Third. A few words may be added as to the method of applying the bandage: the first care to be exercised is that it be not too tight, for it is possible by means of it to force all the blood out of the limb, and quite check the circulation, as when employed in Esmarch's bloodless operations. Ordinarily it need be drawn only just tight enough to perceive that there is the slightest possible stretching of the rubber, no more. The bandages should be applied from the toes, and with a little care they can be made to fit the limb perfectly with but little stretching, and they need never be "reversed," as in bandaging with cotton or flannel bandages; the heel as a rule need not be covered. I always apply them myself first, and have the patient watch very carefully, taking pains to give a little instruction as I make the turns, and I find that even more ignorant patients in dispensary practice can apply them afterwards very satisfactorily.

It is better to apply the bandage while the patient is in bed; that is, before he leaves it in the morning, and to remove it while in bed, after undressing, and I direct patients not to put the foot to the floor without the bandage. On taking it off at night, the rubber is to be immersed at once in water, and if the odor is very fetid, the water may contain thymol (1:1000), or a small proportion of carbolic acid. The leg is then to be washed off with lukewarm water and dried carefully; if there is still a discharging, eczematous surface, it may be covered with cotton batting, and an ordinary roller bandage or other dressing applied for the night. If there is a raw, exuding ulcer, it may be covered with a rag and any mild protective ointment, as simple cerate, to prevent it adhering; this grease must be well removed by wiping, in the morning, before the application of the rubber bandage. After the leg is dressed for the night, the bandage is to be removed from the water, dried and hung up to air for the night; in the morning it is to be rolled up and applied while in bed, as before stated.

Sometimes I further aid the treatment by having the foot of the bedstead elevated with a couple of bricks, that the blood pressure of the limb may be lessened during the hours of sleep. If the leg is very hot and painful, much relief and benefit may be obtained by making cool applications outside of the bandage, as was done in Case XI.

A caution may be here given in regard to the removal of the bandage. In Case IX. it was left off on a very cold day, and the body was much exposed to cold, and, as a consequence, acute congestion of many parts of the skin of the leg occurred, which nearly developed into eczema, but which happily yielded to prompt treatment; the tissues being softened by the rubber, and the sweat glands having been very active, the chill of the surface

produced a congestion, which threatened serious trouble. In cold weather it might be prudent always to advise some extra protection to the limb, for a while after leaving off the rubber bandage.

Care must also be exercised not to leave off the bandage too soon; indeed, it should be worn for a shorter or longer period after the eczema or ulcer is apparently well; when there are varicose veins the patients are very willing and desirous of continuing the application on account of the constant sense of relief experienced.

A very important point to bear in mind in relation to this method of treatment is, that as a rule, if the bandage is well applied, walking and exercise is a benefit rather than a drawback. In Case II., the patient with sub-acute eczema walked six miles a few days after the application; and Case XV., with a very painful ulcer, rose immediately from bed and walked several miles on the following day, remaining on his feet working, until cured.

Thus far, I have said nothing in regard to cases to which this method is not applicable, and for the reason that such cases have not yet presented themselves to me. Undoubtedly, cases will occur where the rubber bandage cannot be borne, and this side of the subject remains to be yet developed. I can only say that I have absolutely no negative experience to offer.

A word in reference to other or previous mention of the use of rubber tissue in the treatment of skin lesions. The only suggestion of its use at all similar to this of Dr. Martin's, is by Dr. Turney\*, of Circleville, Ohio, who reported having treated seven cases of ulcer of the leg with the application of an Esmarch bandage wound very tight, "as long as it could be borne," (for ten or fifteen minutes) each day. Six of the cases were cured, the seventh one disappeared before the cure was completed; one of the cases was in a woman eighty-five years old, in whom the ulcer had existed for fifteen years. It will be seen that the *idea* in this was quite different from that of the continuous, lightly applied rubber bandage, as described in this paper.

In 1869, Hebra†, made a report on the treatment of certain skin lesions with vulcanized rubber cloth, which he had employed on the suggestion of Hardy, of Paris, made in 1867. In this he reports a certain amount of good results in eczema, and considerable benefit in pruritus and in diseases exhibiting epidermal thickening. But the applications of rubber here suggested are quite and entirely different from those I have described; the applications of Hardy and Hebra were made of rubber *cloth*, totally inelastic, and the element of pressure and support to the part are entirely wanting; whereas, the bandages here described are of pure, solid rubber, are extremely elastic, and the pressure and support afforded by them is an all-important element in the treatment.

\* *London Practitioner*, May, 1876, page 367.

† *Archiv für Dermatologie und Syphilis*, 1869, page 1.

I have used the impervious dressings as advised by Hebra, and have had some most excellent results in eczema of the hands from wearing rubber gloves, that is, of rubber cloth. I have also tried the impervious dressings on eczema elsewhere, but have never obtained results on the legs which satisfied me; whereas, with the rubber bandage as here described, the results have far surpassed my expectation.

More recently, Mr. Balmanno Squire\*, of London, has advocated rubber suits of clothing in psoriasis, and has reported some cases in which the eruption was removed in a remarkably short space of time. But this again is but a development of the method of Hardy and Hebra, the suits are made of rubber cloth and there is no pressure exercised.

I have made these references because some, who may have tried the simple application of rubber cloth, or who have even bound it on firmly with a roller bandage, and who have not had good results, might be led to think that the same might be expected from the method advocated in this paper. To these I can only say that there is the greatest difference imaginable between the firm, resisting, non-elastic cotton bandage, and that of soft, pliable rubber, which yields with every motion and yet exercises its ceaseless pressure and support, to an extent which can be regulated to the utmost nicety, with each day's changing condition of the part.

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## ON HYDROA AND OTHER BULLOUS ERUPTIONS.

BY GEORGE HENRY FOX, M. D., NEW YORK.

THERE exists a strong tendency to group under the head of pemphigus all affections of the skin which are characterized by an eruption of bullæ. This is a natural outgrowth of the lesional system of classification, a system which led the pioneers of dermatology to include nearly all papular affections under the head of lichen, all scaly affections under the head of lepra, etc. At the present time the name pemphigus is applied to a particular affection, and at the same time is forced to include many bullous eruptions which bear a resemblance to that affection. Every one whose experience is at all extended, knows that bullous affections of the skin vary widely in their clinical features, and that the nature and causation of these affections must likewise vary is a fair inference. And yet, while all agree that the name pemphigus ought to be restricted in its application,

\**British Medical Journal*, Vol. I., 1876, pp. 311 and 586, and Vol. II., 1876, p. 43.

the problem still remains "what are we to call these other bullous eruptions?"

We have bullous eruptions of every degree of severity; eruptions of trifling importance, giving rise to but slight local annoyance and accompanied by little or no systemic disturbance; eruptions of the gravest import, involving years of misery and a fatal termination.

We have bullous eruptions of widely varying duration; some lasting but a few weeks, others consuming the greater portion of a lifetime; some ending in recovery after a single outbreak, others ending in death after a succession of relapses.

We have bullous eruptions limited to a very small portion of the body, and others involving every square inch of skin from crown to sole.

In erysipelas, urticaria, and certain other affections we have bullæ appearing incidentally, while, in the true pemphigus we see them forming the chief lesion of that terrible disease.

Finally, we have bullous eruptions peculiar to children, appearing in epidemic form, and seemingly contagious, and evidently differing in nature from bullous eruptions met with in the adult.

Surely if there is any field in dermatological study, more inviting than another, it is the careful observation and classification of these somewhat rare and extremely obscure affections.

In Vol. III, No. 1 of this journal, (October, 1876,) an unusual form of bullous eruption was reported as occurring upon the fore-arms of a young man, aged 15, who first came to me in July, 1875. In February last, the young man came to me again with a similar vesiculo-bullous eruption, and the following notes of the case were taken during this second attack.

Feb. 13. Three days ago Henry B., aged 17, felt languid, and on the following day noticed a few scattered vesicles on the back of wrists; these were accompanied by a burning sensation and darting pains; sleep has been disturbed for two nights; face is quite pale and expressionless; tongue coated, though appetite remains fair and bowels are regular. Pulse over 100. Working in a gold-headed cane manufactory, and breathing the fumes occasioned by the immersing of plated metal in nitric acid has evidently impaired his health, and for several months past he has suffered frequently from a dull headache.

The eruption consists of vesicles and flattened pea-sized bullæ, and is most marked upon the backs of the hands and wrists. Most of the smaller bullæ are encircled by a narrow, bright red areola, while some of the larger ones contain a yellowish serum, and exhibit a slight central depression. Upon the scrotum there is a slight eruption, causing him great annoyance. There are white patches on the edge of the ears, where the epidermis is slightly elevated by confluent bullæ, the contents of which have escaped at night from rubbing against the pillow. There are open vesicles on the lips, wing of nose and in centre of the cheek.



The eruption is somewhat itchy, and the desire to rub the affected parts keeps him awake at night. In the daytime he feels better when walking.

Feb. 14. Slept a little better last night. The mouth feels sore from the eruption of a few bullæ on hard palate and buccal membrane. The vesicles on cheek and nose are drying into a honey-like crust. A dozen flat bullæ have elevated the epidermis of the palms. As in the first attack the right arm is worse than the left, but the patches of confluent vesicles are now chiefly upon the hands, instead of on the forearms, as in the former attack. Rubbing or irritating the patches causes them to become more elevated, and though differing in appearance, the eruption has many features in common with erythema papulatum. The serum in the bullæ is slightly alkaline.

Feb. 15. The eruption is somewhat better. There is a lessening of the local temperature, and the inflammatory areola of the bullæ is fading. The bullæ in confluent patches are shrivelling and the elevated epidermis appears whitish upon a pale red background. The numerous isolated bullæ on hands and fingers look very much like variola pustules when viewed at a short distance. The finger-ends feel sore when he buttons his clothes. The small bullæ on scrotum are drying into thin dark crusts.

Feb. 17. The hyperæmia is still lessening, and the raised epidermis presents a dull leaden hue. The yellowish crust has fallen from cheek and left an abraded surface. Appetite fair, bowels regular. Patient pale and weak. Slept well last night.

Feb. 18. Pain in right wrist on motion. The serum mostly absorbed from bullæ, leaving a thick, dry, dull whitish skin. A raw spot on wing of nose. Crusts on lips which give pain when eating. Is feeling better.

Feb. 20. Every joint sore to-day. A crop of small confluent vesicles or bullæ appearing on elbows and back of left wrist. Some of the vesicles assuming a circular arrangement. Finger pulps sore again. A few fresh vesicles on scrotum. Didn't sleep at all last night. Epidermis on back of right hand beginning to look quite dry and dark. Feet beginning to feel sore.

Feb. 24. Can't walk on account of eruption on feet. Scrotum worse. Arms much better. Dead skin peeling off.

Feb. 27. Has improved steadily for three days. White, dome shaped, pea-sized bullæ in palms, containing a cloudy serum.

March 1. A red elevated patch of skin below left eye, but no blebs. The last crop of vesicles has disappeared rapidly by absorption of serum, leaving a thin dark skin or scab. The bullæ are most persistent where the skin is thick. The small bullæ on scrotum being irritated by walking, became purulent, and have left thin crusts. Feels as well as ever.

March 4. The hands are desquamating, and red patches indicate the site of previous bullæ. Scrotum is of normal appearance. Feet nearly as well as hands.

[A painful condition of the feet occurring a few weeks previous to this attack, was thought, at the time, to be the result of "frosting," but patient is now convinced that it was similar in nature to the condition which is just passing away.]

March 8. Entirely well.

The treatment in this case consisted in giving small doses of a tincture of the rhus toxicodendron, which seemingly produced an effect in lessening the local pain and checking the development of the bullæ.

As it will be evident to the reader, that the patient, whose history I have given, suffered from one and the same affection in both attacks, let us glance now at the features of the eruption, and while striving to gain an approximate idea of its nature, seek to give it an appropriate name.

1. *Lesion.* The characteristic lesion of the eruption was a *bullæ*, which either began as such or developed rapidly from a vesicle. This vesicle sometimes sprang from skin of normal hue, but was usually preceded by a congestive macule.

2. *Size.* The bullæ were mostly pea-sized. In the first attack a few were as large as a hazel nut, and one of walnut size.

3. *Contents.* The bullæ contained a clear, slightly alkaline serum, which became more or less turbid in a few days. This disappeared by absorption, as a rule, leaving nothing but dead epidermis. In some instances a honey-like crust, or a thin blackish scab was formed.

4. *Location.* The favorite seat of the bullæ was the fore arms and hands, and particularly, the extensor surfaces. The eruption showed no tendency to develop above the elbows. The ears, cheek, nose, oral cavity, likewise scrotum and feet were affected only in the latter attack.

5. *Configuration.* The bullæ showed no tendency whatever, to corymbiform development. There were no clusters, such as characterize herpes and certain forms of syphilis, but there were irregular patches formed by a confluence of individual lesions, such as are met within lichen planus, eczema, etc. In the second attack, a tendency to a circular arrangement of a few bullæ was noted, but not around a central bleb as are seen in the Herpes iris of Bateman.

6. *Course.* The eruption began with small congestive macules or with vesicles, or very small bullæ, which rapidly increased in size, and were surrounded by an inflammatory areola. While a few bullæ in the first attack became full and tense, nearly all in the second attack were flattened, and many presented a central depression.

A tendency to successive crops of bullæ was observed in the second attack.

7. *Duration.* Three weeks seemed to be the time required for the affection to run its course in both attacks.

In a case, observed in May, 1877, in which the bullæ appeared

on the face, neck, and backs of hands, the duration was likewise between three and four weeks.

It is evident that the affection from which this patient suffered, was one of internal origin. A marked impairment of health was undoubtedly a predisposing course, and the affection may justly be classed with certain other cutaneous affections, whose nature is by no means well understood, but which, certainly partake of a neurotic character. In many features the eruption bore a resemblance to erythema papulatum, and to urticaria bullosum, and like these affections, it was undoubtedly dependent upon a derangement of the vaso-motor system.

For this eruption and for all bullous eruptions possessing the same clinical features, I consider the term hydroa to be a convenient and appropriate title.

Under the name hydroa, Bazin has described an affection to which the eruption, which we have just been studying, closely corresponds. His division of the affection into three varieties, viz : *H. vésiculeux*, *H. vacciniforme* and *H. bulleux*, seems to me to be unnecessary, as in the case of our patient the three varieties, or at least two of them, evidently co-existed. The statement of Bazin, that in *H. bulleux* the bullæ do not exceed the size of a pea, would not seem to be borne out by the first attack from which our patient suffered, as in this case many of the bullæ were much larger. The duration of the affection, furthermore, instead of being from four to six months, was less than one month, and corresponded in this respect to his *H. vésiculeux*.

Hutchinson who has written several articles on the subject of bullous affections, speaks of hydroa as a symmetrical eruption, always sudden in its outbreak. It affects by preference the face and forearms, but although it never exempts these parts, it may in rare instances occur over the body generally. The bullæ vary in size from a pea to a half cherry, surrounded by an erythematous base. At the outset they bear a strong resemblance to variola, but do not become umbilicated. Their contents become gray and opaque, but not distinctly purulent. He further speaks of shilling-sized patches, with vesication spreading at the margin, and with a sinking of the central surface. The affection lasts from a few days to several weeks. (The majority of the cases, according to a comparatively recent paper on the subject, H. regards as resulting from the use of iodide of potassium.)

The description of hydroa given by Hutchinson, corresponds to the eruption observed upon my patient, even more closely than does the description of the forms of hydroa found in Bazin's work, and, it is very clear to my mind that the hydroa of Bazin, the hydroa of Hutchinson, and the affection from which my patient suffered are identical.

Tilbury Fox, mentions in his text book a number of anomalous bullous eruptions, and seems disposed to connect them all with herpes on the one hand, or with pemphigus on the other. He

objects to the term hydroa upon the unfounded assumption that "it clearly signifies a disease connected with sweat." The word hydroa (spelled with a y,) is manifestly from the Greek ὕδωρ, "water," while the terms hidrosis, dysidrosis, etc., derived from ἰδρῶς, "sweat," are spelled with an i, or should be at least when spelled correctly.

An eruption like the one which I have described cannot with justice be ranked as herpes, or disposed of under the convenient title of acute pemphigus. Without denying the possible occurrence of true pemphigus in an acute form, I must insist upon the impropriety of applying the term to all acute bullous eruptions, the vast majority of which bear no etiological relation whatever to the true pemphigus. As for calling the eruption herpes, I will merely say, that it did not present the characteristics of any form of herpes, save the so-called herpis iris, which by the way, is not a purely vesicular eruption as the name herpes would imply. The herpes iris of Bateman, (*hydroa vésiculeux* of Bazin, *pemphigus iris* of Wilson,) is an affection rarely met with outside of the text-books, and one whose clinical features serve to stamp it as a somewhat peculiar form of the affection described by Bazin and Hutchinson.

Under the term hydroa then, we may justly class some vesiculo-bullous eruptions, which are neither herpes nor pemphigus. Other anomalous cases will still remain, and until far more study has been devoted to them than has been the case heretofore, their nature will be doubtful, and even their clinical features will be ill-defined.

## SYPHILIS COMMUNICATED BY A BITE.

BY GEORGE H. ROHÉ, M. D.

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IN recent numbers of the *Allgemeine Wiener Med. Zeitung*,\* Professor Zeissl reports several cases of syphilis in which the infection was communicated in an unusual manner. In the first case the patient had been bitten on the hand during a drunken brawl, the wound being made over the metacarpo-phalangeal articulation of the left thumb. The wound healed, but in a month became infiltrated and ulcerated. In another case, an initial sclerosis followed a kiss upon the cheek; a third was bitten in the right mamma by her lover while performing the sexual act. Two other cases are referred to by Zeissl, one of which is pictured in his work on syphilis. In this case, the patient—a man—was bitten on the chin by his mistress during the act of copulation. The other was published in the *Med. Times and Gazette* about nine

\*Nos. 2 and 3, January, 1878.

years ago, and occurred in the person of a policeman, who was bitten on the finger by a prisoner whom he had arrested. In all of these cases the constitutional symptoms were well marked, and an infection in the usual manner, excluded by thorough examinations.

The following case which has recently been under my notice, adds another to the list of histories of unusual infection—

On the 17th of March last, Dr. Wilmer Brinton, of this city, requested me to see with him a man, who had an eruption on the body resembling a syphilide. I met the patient at Dr. Brinton's office the same day, and subjoin his history as there obtained :—

J. Walker, aged 22, a very light-colored mulatto, oyster shucker by occupation. About Christmas, 1877, he had a difficulty with one of his fellow-workmen, which ended in a fight. During the fight, Walker was bitten in the nose by his opponent, producing a rather severe wound, but which readily healed. About a month after the fight occurred the patient noticed that his nose became sore at the point where he had been bitten. The soreness increased, becoming painful and swollen. A few weeks later the submaxillary glands became enlarged and tender, the tumefaction being more decided upon the side where the bite was. The patient had some fever, sore throat and *malaise*; as he expressed it, "a bad feeling generally." About a week before applying for advice, an eruption of brownish spots, with some pimples here and there, appeared on his breast, back, arms, buttocks and thighs. When questioned regarding previous venereal troubles, he confessed to a clap about three years ago, but denied any knowledge of any sore upon the penis. Inspection of the genitals failed to reveal any lesion or cicatrix upon the penis; there was induration along the course of the urethra; the inguinal glands were slightly enlarged, but not sensitive. He had never suffered from stricture, and had not noticed any falling of the hair.

The lesion at the site of the original injury was found to consist of an ulcer with an indurated base, seated upon the left alar cartilage. The submaxillary and post-cervical glands were enlarged, and the pharynx strongly injected. On stripping him, his trunk, arms and thighs, were found covered with a well-marked erythematopapular eruption, the spots beginning to fade upon the chest, and being apparently succeeded by disseminated pustules, which were most numerous around the neck. These symptoms induced me to confirm the diagnosis of syphilis, the result of the bite upon the nose, without hesitation; but desiring still stronger evidence of the manner of infection, Dr. Brinton and myself, on the following day hunted up the inflicter of the bite which had given our patient so much trouble. On examining his mouth a large mucous patch was found on the left cheek near the labial commissure. The patch had a grayish surface, with shallow fissures running through it in various directions, and a large infiltrated

base. It had existed for some months, but had not received any treatment.

As this evidence was deemed sufficient to establish the diagnosis as expressed at the head of this paper, no further examination was made of the man. Under bichloride of mercury internally, and calomel dusted upon the primary induration, the patient Walker rapidly improved, and is at the present writing, free from any skin eruption.

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## ON THE TREATMENT OF SEVERE BED SORES.\*

BY DYCE DUCKWORTH, M.D., EDIN :

*Fellow of the Royal College of Physicians ; Examiner in the Practice of Physic in the University of Edinburgh ; Assistant Physician to Saint Bartholomew's Hospital, London ; and formerly Demonstrator of Skin Diseases.*

IN this short communication to the Association of American Dermatologists, I desire to call attention to some methods of dealing with severe bed sores. I have no intention to offer any suggestions respecting the preventative treatment of these troubles, because this subject is now very properly relegated to the attention of skilled nurses, who are happily being trained in this country and elsewhere in large numbers. I allude therefore to those grievous cases of large and deep sores, which no treatment has availed to avert, and which come at once under the care of the practitioner. The worst instances are met with in heavy patients, in those of large build, with flabby and imperfectly nourished integuments. This class of cases is chiefly furnished by the subjects of acute disease of the spinal chord, myelitis more particularly, and in such instances there is not only the direct risk of irritation from involuntary passage of urine and feces consequent upon paralysis of the sphincters of the bladder and rectum, but there is also a special vulnerability of the integuments dependent upon a rapid failure of their ordinary nutrition. Every educated physician and sick-nurse should know that all cases of this nature should be immediately placed upon a large water-bed in anticipation of such calamitous results as must inevitably ensue from neglect of such precaution. Two or three days of inattention to this point, together with imperfect nursing, will suffice to induce the worst forms of bed sore to be met with.

When such a grievous trouble is added on to the special difficulties of these cases, how is it to be met ?

I wish to recommend that, in addition to the use of a water-bed the patient should lie with the buttocks and sacrum constantly upon poultices. These poultices should be made of linseed, (or as termed in the United States flax meal,) and if there be much discharge or fœtor, the cataplasma carbonis of the Pharmacopœia should be used.

\*Read before the American Dermatological Association, September 4th, 1877.

Since the introduction of so-called antiseptic principles in surgical practice, some objection has been made to the use of poultices in anyway, either to a broken or unbroken surface. They are supposed by some to be centres of mischief and unwholesomeness in themselves, and to produce unhealthiness of wounds. I wish to record my protest against this temporary wave of fashion in therapeutics, and to put in a plea for a little common sense and attention to plain clinical facts, *versus* theory and speculation evolved in the study, and *not at the bed-side*. I take it for granted that these poultices are made of pure flax meal, and that they be frequently changed, the old ones being immediately burned, and not again warmed up as is the custom in some French hospitals. They must be large, so as to cover all the affected parts, and if there be excavated sores over the trochanters these must be also covered, and a binding sheet secured over the abdomen with safety-pins.

In the case of there being any sloughing portions of muscular and fibrous tissue in the wounds, and also if the wounds be flabby or languid, the addition of balsam of Peru to the poultice becomes highly desirable. If there be deeply excavated sores, plugs of lint smeared with the balsam, should be placed in the cavities, and the edges of the wound be gently compressed by strips of diachylon plaster.

If the wounds become unduly vascular or granular, dossils of lint dipped in zinc- or copper-sulphate lotion, (two grains to the ounce) are very useful for a time, and should be placed in the cavities as described.

It will be found necessary to persevere with the poultices till the bed sores heal, and this is sometimes a matter of many months.

The practice here recommended is that which is followed with much success in St. Bartholmew's Hospital. I am not aware to whom is due the particular credit of the measures herein urged.

Quinine in doses of two or three grains, thrice daily, is of service in the treatment of the general constitutional condition of such patients, but of course any other medicinal treatment can be carried out if required for the special lesions which have led to the complication.

## ACUTE CONDITIONS OF DISEASE EXCITED BY THE IODIDE OF POTASSIUM.

BY ALMON BROOKS, M. D., OF CHICAGO.

**E**MPLYING the Iodide of Potassium in unusually large doses, in a great number of cases of specific disease under treatment at the same time, my attention became directed to the circumstance of the frequent occurrence of certain symptoms of an acute character; these symptoms were non-specific; they were observed in not all, but certainly, in a greater or less degree, in a majority of the patients; they generally subsided when

the iodide was discontinued, and recurred often, when its administration was resumed, and were greatly aggravated by the further immediate employment of the medicine.

These phenomena of acute disease are seen more constantly to follow the ingestion of large quantities of the *iodide* in a brief period of time. In regard to their essential pathological character I regard them as identical with certain manifestations of the poison of gout, which manifestations they very exactly resemble in their symptomatology.

The declaration that iodide of potassium is a frequent exciting cause of acute gout, may now be received with a degree of doubt, but as attention is called to the subject, other observers will I believe, not fail to recognise as a truth in medical science.

The most frequent and important manifestations of gout excited by the iodide, are : *fever*, *arthritis*, and *iritis*. For the sake of variety and clearness, I shall speak of these as the *fever of the iodide*, the *arthritis of the iodide*, the *iritis of the iodide*, to distinguish them from the similar groups of symptoms excited by causes other than the iodide.

The *fever of the iodide* is characterized by the usual symptoms of fever, as seen in the subjects of recurring paroxysms of acute gout, during the day or two just preceding the appearance of the inflammatory process of the disease in the joints ; the bodily temperature is moderately elevated above the healthy standard, the pulse is quickened, a peculiarly disagreeable taste is complained of, together with gastric irritation and much physical depression. But the significant symptom is the marked predominance of aching about the joints and muscles, with soreness and stiffness of these parts, and pains generally about the head and face, of a neuralgic type.

The fever of the iodide may continue one or two days after the medicine has ceased to be taken ; its cure is hastened by purgation, but usually it disappears simply by discontinuing the administration of the iodide. Recurrences of this fever will be observed every few days in many patients, especially if the iodide is being ingested in rapidly increasing doses. Such recurrences greatly embarrass specific treatment, and, for a time may render it wholly abortive, unless it be known that they may be averted by the timely administration of a purgative dose of tincture of colchicum and calcined magnesia. The patient soon learns to rightly apprehend the premonitions of the fever, and to apply the prophylactic in due season, and thus be enabled to steadily continue the taking the of iodide. Paroxysms of fever in patients taking large doses of the iodide of potassium occur as nearly as frequently as attacks of nasal catarrh under the same circumstances. There are contingences when life may be sacrificed, if the physician is unable to apply the proper means for the prevention of the *fever of the iodide*, and at the same time continue the administration of the medicine causing it.



The sudden supervention of *fever* in a large percentage of persons taking the iodide of potassium in large doses, its disappearance upon the withdrawal of the medicine, its recurrence when the administration of the medicine is begun again too soon, its aggravation if the iodide be further ingested in its presence, all seem to prove that the *fever* is a consequence, directly or indirectly, of the ingestion of the iodide.

Generally upon the advent of the *fever of the iodide* patients omit, for the time being, the further use of the medicine, on account of the local and general symptoms of distressing character, which they regard as a consequence of its employment. Exceptionally, notwithstanding the omission of the medicine, patients with the *fever of the iodide* will fail to experience defervescence in the usual time, and will soon become the subjects of *arthritis*, in one or more localities.

If patients with the *fever of the iodide* still in an active state, persist in taking the medicine, almost invariably a general *arthritic* attack will be produced, and may prove of several weeks duration, unless some preparation of colchicum be employed against it in efficient quantities.

The attendant symptoms of the *fever of the iodide*, and the fact that its prolongation and intensification terminate in *arthritis*, seem to prove that the two morbid states are but different manifestations of one and the same disease. Now what is this one disease, which is characterized by a brief preface of fever, followed by inflammation of joints, curable in a few days by colchicum? What can it be but *gout*? Direct experiment, I am satisfied, will demonstrate that the salts of uric acid rapidly increase in the blood of persons taking large doses of the iodide of potassium, provided the test be applied before the system has, by long use, acquired a kind of tolerance of the drug. There are certain facts which may be regarded as strengthening my conclusions, facts such as these: In the subjects of frequently recurring paroxysms of acute *gout*, *fever* and *arthritis* are at once produced by large doses of the iodide of potassium; cutaneous maladies in whole, or in part, having the relationship of effect to the poison of *gout*, are immediately much aggravated by large doses of the iodide; the diet, drink and manner of life that exaggerate the gouty tendency, also render the system less tolerant of the iodide; the *fever*, *arthritis* and *iritis* of the iodide, and the ordinary manifestations of acute *gout*, are with equal promptitude removed by colchicum; when a person becomes the subject of the *fever*, *arthritis* or *iritis*, of the iodide, the morbid manifestation will be increased by the continued administration of the iodide alone; but if colchicum be also given, in appropriate doses, the morbid manifestations will at once disappear.

Cases of the *iritis of the iodide* are constantly falling under my observation. The importance of their general recognition cannot well be exaggerated. The diagnosis is rendered very certain by

the fact of the appearance of the disease, when symptoms of an undoubted specific character are receding under treatment. I not long ago directed a patient, with a *tubercular syphilide*, to take the iodide of potassium in increasing doses ; the amount ingested daily had been advanced to ninety grains, under the influence of which his specific eruption was rapidly receding. Suddenly he became the subject of *iritis*. At the time in a distant city, under the instruction of an oculist, he applied atrophine, and took mercurial pills in conjunction with the iodide. Still the affection of the eye persisted, and seemed to grow worse, until the iodide was omitted, and tincture of colchicum in fifteen minim doses was taken every four hours. In less than forty-eight hours after beginning the use of the colchicum, the change for the better in the eye was something bordering on the marvellous. Too early resumption of the iodide, in this case caused a partial relapse, but the addition of one or two daily doses of the colchicum to this treatment removed it. For two or three weeks after the *iritis* had disappeared, a dose of the colchicum was taken every night, and the local affection of the eye did not further embarrass the treatment of the specific malady.

An investigation concerning many recorded cases of supposed specific *iritis*, reported cured by measures inefficient against the genuine manifestations of syphilis, has convinced me that the *accidental complication* has very often been mistaken for the real disease by some of the most acute observers.

The human economy it seems, can safely, and even comfortably, tolerate an almost incredible amount of the iodide of potassium, provided it be taken in very gradually increasing quantities, beginning with a small dose. Rapidly destructive lesions of the skin, however, in situations exposed to general observation, as well as dangerous affections of vital organs may require for their immediate arrest, large and frequently repeated doses of the medicine. Under precisely such circumstances, when every hour is precious, the administration of the iodide is likely to be embarrassed by the development of some of the morbid effects before described. The study of these morbid effects, and a correct knowledge of how to obviate them, are matters of the greatest importance.

The iodide of potassium, it is well known, is mainly eliminated by the kidneys. In small doses it may have proved a renal depurant ; but when it occupies, in large amount, the excretory channels of the kidneys, it is highly probable, that it constitutes a mechanical obstacle to the escape of the salts of uric acid.

## NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.\*

BY L. DUNCAN BULKLEY, A. M., M. D.

*Physician to the Skin Department, Demilt Dispensary, New York; Attending Physician for Skin and Venereal Diseases, at the New York Hospital Out Patient Department, etc.*

XIX. *Nævus*.—The treatment of the two kinds of *nævi* must be considered separately, as the pigmentary and hairy *nævi* require somewhat different measures from those deformities which are more commonly recognized as such, vascular *nævi*; I will speak of the latter first.

Vascular *nævi* again, require measures which are different according as the disease is of the flat or protruding variety, the latter come more properly under the consideration of the surgeon, and I will confine my remarks to the more flat forms, commonly known as mother marks, or birth marks, or *nævi-materni*.

The object to be attained in the treatment of these disfigurements is to induce such an inflammatory or other alteration in the enlarged capillaries as shall cause their obliteration, and for this purpose various measures have been advised. Injections of irritant and astringent substances, as perchloride of iron, etc., have been employed, but some cases of death have been reported following this means, and it is seldom now resorted to. Vaccination upon the *nævus* will in a measure remove the vascular deformity, but this can, of course, only be practiced once, and in an unvaccinated person, and, moreover, the resulting scar on an exposed surface would be little if any less disfiguring than the original deformity.

The practical measures for the relief of vascular *nævi* come under three heads: first, superficial cauterization with chemical or thermic means; second, electrolytic action; and third, operative interference surgically.

Smaller *nævi* may be caused to disappear by touching the surface well with fuming nitric acid, also with strong solutions of caustic potash (3 ij-3 vj ad 3 j), likewise by pustulation induced by such agents as tartarized antimony (gr. x-xx ad 3 j empl. resinæ.) Superficial touching with the actual cautery, either heated in the lamp, or as in Paquelin's gas cautery, or, with the galvano-cautery, will be found successful in smaller *nævi*. These touchings are made rather superficially, and with not too great heat, a dull red being better than glowing white.

\*These notes are intended to report for the use of the general practitioner, the local measures in common use by the writer in the treatment of diseases of the skin, and which may be safely employed; it is not intended that they shall be exhaustive, nor that these measures are recommended to the exclusion of constitutional treatment; the formulæ are not claimed as original, although some of them may be. These "notes" are continued from pages 212 and 307, of Vol. II., pages 24, 127, and 324, of Vol. III., and page 49 of Vol. IV.

Electrolytic action has been reported on, very satisfactorily by a number of writers. I have never employed it. The needles of the positive pole are to be thrust into and under the nævus and a negative sponge electrode rests on the skin near by; or in larger and deeper nævi, both poles may terminate in needles, which are thrust into the lesion. There is danger of producing sloughing by too strong currents or too prolonged applications. The operation should be performed under ether; a current developed by from six to twelve cells is sufficient, and ten minutes generally suffices to produce coagulation. This method is of great service in the larger and more vascular nævi, even those subcutaneously situated.

Surgical or operative measures are successful if performed with requisite skill. Smaller nævi may be excised, and in certain situations this is the best procedure; larger nævi may have portions excised from time to time, the scarring being thus less than if removed entire. Two new methods of operative interference have been reported on of late. Mr. Squire of London, advises scarifying nævi, especially the superficial "port wine marks." The incisions he makes exactly parallel, and to the depth of about one-sixteenth of an inch, and at distance also of about one-sixteenth of an inch apart; the part is to be first frozen with ether spray. These operations require to be repeated several times, and the direction of the incisions each time, is to be at an angle to the former cuts. The after treatment consists in pressing blotting paper gently on the surface, being very careful not to allow the cuts to be pulled apart, lest a wider cicatrix result. Dr. Squire has recently invented a knife with many blades cemented parallel to each other for this operation.

The method of Dr. Sherwell of Brooklyn, \* consists in repeated tattooing of the nævi by means of a bundle of needles, dipped in a strong solution of carbolic or chromic acid, (twenty to forty per cent.,) and the subsequent coating of the surface with several layers of collodion, first wiping it off with alcohol. The *idea* in both of these processes is somewhat the same, namely, the multiple division of the blood vessels in such a manner, as to cause adhesive inflammation.

Comparatively few cases of nævi apply for treatment, many persons being even averse to having them removed, from superstitious reasons, but the physician should always bear in mind that every method of removal will be followed by more or less of a scar, and should always acquaint the patient with this fact. He should also see to it that the scar is not more disfiguring than the disease. Superficial cauterization with strong nitric acid is least liable to result illy; the actual cautery gives a deeper and more contractile cicatrix, and should be employed on a small surface at once. Electrolysis may result in considerable sloughing, and should be cautiously proceeded with: excision always leaves a scar. The methods of Squire and Sherwell are said to leave scarcely, if any,

\* Archives of Dermatology, April 1877, p. 214.

cicatrix, but they have the objection of requiring repetition, perhaps a considerable number of times.

Pigmentary and hairy nævi are seldom so large that they cannot be readily removed by excision ; if this is neatly performed, there need be but a slight linear scar. When larger, they may be removed piecemeal, or successive portions may be destroyed by caustics, of which nitric acid and caustic potassa are the best. But it must be remembered that such nævi always leave scars, as the new deposit of pigment, or the new connective tissue or hairs are so deeply seated that their removal must be followed by deposition of cicatricial tissue.

XX. *Onychia and paronchia*.—Inflammation of the bed of the nail is sometimes a very painful and annoying affection to treat ; where it is due to syphilis, the treatment of that state is, of course, necessary to a cure. I have had most excellent results, (and so uniformly that I almost invariably prescribe it,) with an ointment composed of the liquor ferri subsulphatis ( ʒ j ad ʒ j ), kept continuously and freely applied. The nitrate of lead in powder applied freely has been highly recommended. I have also seen very severely inflamed onychia completely heal in a very short time under powdered iodoform, plenteously dusted on.

Where an ingrowing nail causes the trouble, it should be carefully clipped by the physician, and a bit of lint or kid smeared with the sulphate of iron ointment carefully inserted.

XI. *Pemphigus*.—Little is to be said in reference to the local treatment of pemphigus ; it is all comprised in the word *protection*. The very best covering for abraded surfaces, as in a blister, is undoubtedly the cuticle which has been removed, therefore in treating skin diseases in which blisters or bullæ occur, we should be exceedingly careful to preserve the natural covering, if possible, or afford the raw surfaces some equally bland coating. Powders, as starch and lycopodium should therefore be used when the blisters are unbroken, to form a smooth covering over which dressings may slip without friction.

When the cuticle is broken such washes as that of prepared calamine and oxide of zinc, as described under eczema and erythema, often afford the most relief. If the surfaces are really abraded and need protection, a very mild oxide of zinc ointment, (gr xv ad ʒ j,) in rose or cucumber ointment, or Goulard's cerate diluted several times, forms the best protection. The great danger in the local applications is in making them too strong, too stimulating.

(TO BE CONTINUED.)

## Clinical Reports.

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### *I. Case of Recurring Exfoliative Dermatitis of the Hands and Feet.\** BY L. DUNCAN BULKLEY, A.M., M.D., New York.

Mr. A., aged 23, a graduate of Princeton College, and now a law student, has enjoyed only fair health, having been subject to sickness of various kinds since very young. He had scarlet-fever at five years of age, and again (?) at ten years, followed by inflammatory rheumatism, and jaundice. The "peeling" of the skin after the second attack of scarlet-fever affected the hands and feet in an excessive manner, much resembling the present attack of exfoliative dermatitis.

During the interval between 11 and 14 years of age he had a number of attacks (half-a-dozen) of the "peeling" of the hands and feet, after which he had no recurrence of the disease until 1873, when he had one attack. The next one occurred in 1876, when he was 21 years of age, and during this year he had four successive repetitions of the same at intervals of a few weeks; the hands and feet were next affected once during the summer of 1877, and the next attack was the one with which he applied for treatment February 11, 1878. This was followed by the attack with which he was presented to the Society, March 26, 1878.

The attacks are almost if not quite always preceded by symptoms which predict their occurrence. A week or so previous to the appearance of the disease he will have more or less indigestion and malaise, and very commonly a "boil" will appear, generally somewhere about the face: he can thus be certain that in from a week to ten days the hands and feet will go through the scaling process. The actual disease in the extremities will begin very suddenly, with a burning or tingling sensation, especially when moved, which once occurred during the night. The hands are then swollen, stiff, hard, and dry, of a purplish red color and tender if pressed upon; in a week or ten days (the hands remaining in above con-

\* Patient presented before the New York Dermatological Society, March 26, 1878. For discussion see page 235.

dition during this interval) the skin begins to separate, especially on the palms, cracking at the flexures ; the skin on the feet begins to peel a week or more later.

There is no moisture at any time associated with the disease ; there are never any papules or vesicles or any separate lesions of any kind ; the epidermal layer simply peels off, dead, much as in scarlet-fever, leaving a perfectly formed, slightly reddened epidermal surface beneath. If the hands are not oiled or protected by gloves, the separation takes place pretty rapidly and the new epidermis again hardens and may be shed two or three times in a single attack. The nails are always affected and show clearly by ridges when the disease was at its height ; several of these have been seen on the nail at once. When the attack is severe there may be a slight rash over the abdomen, or even a more general one, which will subsequently scale to a moderate degree.

When first seen, February 11, 1878, the local disease was at its height ; the inflammation had begun in the hands nine days previously, a slight attack of indigestion had preceded it, and a "boil," as he termed it, had begun on the left cheek fourteen days before. The pulse was 102 and of fair strength, the tongue, which had as usual been much coated, had shed its epithelium and was red at the tip, with elevated papillæ ; the bowels have always a tendency to constipation, and the urine is apt to be high-colored. The hands were then "peeling" and he stripped off large masses of tough epidermis from the palms.

The attack from which he now suffers is the second one which I have witnessed : it commenced with the formation of a large lymphatic-like swelling on the left jaw, covering an area of nearly two inches in each diameter : this began about March 4th, or one month after the beginning of the previous attack ; there was some pain in it at first, but when seen it was indolent and almost painless when handled. He called at my office with this on March 11th, and on the next night he was wakened by the peculiar burning and prickly sensation all over the palms, and slightly in the feet : the parts began to harden immediately, and when he next called, March 20th, the separation of the epidermis had begun. The mass on the right cheek had discharged spontaneously and had diminished considerably in size. The tongue presented the same appearance as before, having shed its coat, and being very red and with greatly elevated papillæ at the tip ; the appetite was poor and he felt very poorly. He expected the hands to "peel" very rapidly, but consented to wear gloves continuously, to preserve the skin intact for inspection at the Society, March, 26th.

The present condition may be thus described : Both hands (and feet) are the seat of a desquamative process ; the palms have a thick, opaque epidermis still attached, but which may be separated in large masses ; on the backs of the hands the epidermis comes off in smaller portions. On lifting a portion of this cuticle, where it is cracked at the flexures, it is found to be yet quite

firmly attached, but may be pulled off without giving any pain, and the epidermis beneath is found perfect, exhibiting the normal furrows quite as distinctly as that which has separated. The nails show plainly the ridges caused by the previous attack, which have advanced about one-sixth of an inch from the base of the nail. He exhibits a piece of epidermis stripped from the foot, which is about the width and shape of the sole, and seven or eight inches in length. The remains of the lymphatic-like swelling on the left cheek are still evident, somewhat reddened, but without tenderness.

*Note.*—*June 25, 1878.* The patient has been under constant observation and treatment since. The urine was examined and found to contain neither sugar nor albumen, specific gravity 1025 and 1026, both morning and night specimens were very acid, but no crystalline deposit took place.

On April 15, a little over a month after the appearance of the previous lymphatic-like swelling of the cheek (his "boils"), two hard, nodular masses were felt beneath the chin, a little to the right side, and one behind the right ear, evidently lymphatic in nature; the former were of recent date (a week), the latter had been there a year or so. On April 20th, again about a week after the appearance of the swellings, he had a third attack of the "peeling" of the hands, which, however, was much less severe than the former, the epidermal layer shed being much more superficial.

On June 0th he had a fourth attack of the burning of the hands, but no peeling followed, and the unpleasant sensation passed off in a day. Again, on June 19th, he was threatened with the burning and tingling, but no epidermal ex-foliation took place. He has been under the iodide of sodium in five, increased to ten grain doses, three times daily, since April 15th, (Blancard's pill were added later) under which the lymphatic swellings beneath the chin and behind the right ear have softened very greatly and diminished in size; at the same time the attacks have been decreasing in severity. He thinks also that benefit has been obtained by the local use of very hot water to the hands at night, followed by the application of diachylon ointment.

## II. *Clinical Conversations on Diseases of the Skin.\** BY THE EDITOR. *Reported by Robert Campbell, M.D.*

**CASE I.** *Papillomatous epithelioma.* This old woman, of 73 years, presents a lesion which is not a little peculiar, and which you should be able to recognize with a certainty, because unless the correct diagnosis is made you may make a grave error in treatment.

\*Cases shown and remarks made to private classes, at the Demilt Dispensary, New York.



She states that something over a year ago she bruised the ulnar side of her left hand while scrubbing, and that some charcoal got into the wound. The spot has never healed since, but has remained open, the disease gradually extending up to the present time, while it has partially healed in the center. She has used various remedies but with no effect.

The lesion you see may be thus described : On the outside and back of the left hand, reaching from the end of the ulna to the first joint of the little finger, and from the meta-carpal bone of the middle finger around almost on to the palm, is a mass of diseased tissue, composed of tubercular elevations and papillary prominences surrounding a strip of cicatricial tissue, which is much shrunken and evidently involves the entire structures to the bone, over which it slips readily. The most characteristic portion of the eruption is seen at the wrist, where the disease extends almost around the member, where it is composed of papillary prominences, some of which would measure nearly a line from base to summit ; some, you see, are very pointed and thin, almost filamentous, while others are larger ; but each single papillary growth stands separate, and is covered with a thin epidermis. In some places there is a moderately adherent, dirty scab, quite thin, and as we remove this, and scrape the projections blood flows very easily.

Now this lesion might be mistaken for syphilis or lupus, but these are the only two diseases which it at all resembles. She gives no history of syphilis, and there are no other lesions now on the body, nor any scars ; moreover, the very slow character of the development of this disease precludes syphilis ; also, in the gummy syphiloderm you never have such remarkable papillary prominences as these. Lupus you would very rarely see in a person of this age who had not borne it for a long time ; lupus almost never appears after the age of 70 as did this. There is no real ulcerative surface, as there would be in a lupus which had caused such a destruction as this ; there are no crusts. Epithelioma, as you know, is a disease of adult life, and not uncommonly develops first in old age ; here on this woman's nose also, you see a small pearly epitheliomatous growth, which is perfectly unmistakable, and this curious lesion on the hand we must regard of the same nature.

In regard to the treatment of the case, thorough scraping, followed by the actual cautery would probably cure it ; but her age and situation in life, as an out-patient, forbids this ; the disease is improving slowly under citrine ointment, three times diluted.

• (TO BE CONTINUED.)

## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

REPORTED BY DR. P. A. MORROW, SECRETARY.

*Ninety-first Regular Meeting, February 26th, 1878.*

DR. F. P. FOSTER, PRESIDENT IN THE CHAIR.

The following cases were exhibited to the Society :

DR. BULKLEY presented a case of *lupus vulgaris*.

DR. BULKLEY presented a case of *superficial epithelioma*.

DR. BULKLEY presented a case for diagnosis.

DR. BRONSON presented a case of *lichen planus*.

DR. FOX presented a case of *venereal sore* for diagnosis.

DR. STURGIS presented a case of *venereal sore* for diagnosis.

DR. SHERWELL presented a case of *supposed pemphigus* for diagnosis.

DR. BULKLEY presented a patient with *lupus vulgaris*, the fifth one he had exhibited before the Society, and also one with *epithelioma*, in order strongly to contrast the clinical features of the two lesions.

#### **Lupus vulgaris.**

Elizabeth G., aged 34 years, married, never had any eruption until last May, 1877, when a small patch made its appearance on the right side of the face, near the nose. When first noticed she was at sea, coming from England.

The lesion is about two inches in diameter, irregularly circular, with well defined margins, composed clearly in some places of separated tubercles. The diseased tissue has a pulpy feeling, is of a dark, purplish red; the surface is covered with scales to a moderate extent, and the scales tend to roll up, being tolerably well attached at one edge. The eruption causes no pain or inconvenience of any kind, and has never been subjected to treatment, except of a palliative nature.

#### **Epithelioma.**

Maria M., aged 43, single, first noticed a small spot on the bridge of the nose, twelve years ago; she thought it originated from a severe blow, which she had received a few years before on a door in the dark. The lesion as first noticed by her was hard and white, and not at all painful. It has never been cured, but has remained and increased since the first, after healing in part

for a while in some places, only to extend somewhere else. The disease has been subjected to considerable treatment, caustic and other; she had received electrolytic punctures five or six times.

The lesion may be thus described: On the bridge of the nose, at the root, extending up on to the forehead and to each inner canthus, and down on the nose, to a distance of about an inch either way, is a mass of cicatricial tissue and active disease. The cicatrix is red, and of moderate tensity; the active masses are hard, rising distinctly above the surface both to the touch and sight, and are in part of a pearly whiteness, and of a light red color. The diseased tissue borders the cicatricial, and is evidently advancing continually upon the adjoining healthy tissue. No portions of it are at present moist or crusted, nor is there any of the scaling observed in the preceding case.

The greatest contrast exists between the feeling of the almost cartilaginous-like tubercles of the epithelioma, and the soft, pulpy tubercles of the lupus.

In the discussion which followed:

DR. KEYES remarked, with reference to Dr. Bulkley's first two cases, that he regarded them both as lupus vulgaris. Number two recalled to his mind a case upon which he had operated some years before. The lesion in that case was in situation and general appearances almost identical with this. The disease was entirely cured by the operation and subsequent treatment, and did not again recur. A careful microscopic examination failed to discover any of the peculiar cell formations which characterize epithelioma.

DR. PIFFARD regarded the second case as lupus vulgaris, or what he would, by preference, term tubercular scrofulide. Its appearance was not suggestive to him of epithelioma. He was positive that the "stratified cell nests," which characterize an epitheliomatous growth, could not be found in this case.

DR. ROBINSON thought the first case was lupus, the second epithelioma.

DR. FOSTER regarded Case No. 1 as lupus erythematosus. The sebaceous glands and follicles seemed to be markedly involved. Number 2 he thought a case of lupus vulgaris. While he would not deny that it presented some of the aspects of epithelioma, yet he had never seen an epitheliomatous lesion cicatrize as in this case. The marks of extensive cicatrization were plainly evident.

DR. STURGIS said that he had often seen epithelioma cicatrize, although not so extensively as was here presented. In this case, however, the sharply defined tubercles, the hard, cleanly cut border, and the characteristic induration, left no doubt in his mind that it was epithelioma.

DR. BULKLEY presented the following case for diagnosis:

Patrick Organ, 15 years old, was first seen at Demilt Dispensary October 31, 1876. He has always enjoyed good health until sometime in 1871, when an eruption, which his mother called the

"hives," made its appearance on the abdomen. This eruption has remained to the present time; he has never been free from it, although it is somewhat better during the winter. There is no history of eruption in the family. The mother has had seven children, five of whom are living, and two dead, as follows: Patrick, 15 years old; second, who died of diphtheria when seven months old; third died when three weeks old of pertussis; fourth, a girl 10 years old, who has an anæmic appearance, and has had attacks of hæmoptysis; fifth, a boy 8 years old; sixth, a girl almost 7 years of age; and seventh, a girl 4 years old. No history of syphilis can be made out.

When first seen, Oct. 31, 1876, the eruption presented the following characteristics: The body is covered with a number of papulo-tubercles, some just forming, others in stage of retrogradation; they are of a coppery color, and somewhat elevated. The face, body, and limbs are covered with a number of scars, resembling in appearance those of small pox, somewhat depressed in the centre; the older ones are quite pale and supple. There are also new tubercles in the face, isolated, which are just making their appearance; these tubercles also exist on the upper and lower extremities, and backs of the hands—the palmar surfaces of the hands and the feet being spared. On the extremities the eruption occupies more especially the flexor surfaces. New tubercles are constantly making their appearance, the old ones drying up and leaving the scars before mentioned. At first there was a great deal of itching, now there is none. There has been no history of syphilis, hereditary or acquired; no keratitis; no rheumatism; no alopecia; no post cervical adenitis. There is, however, on the left ala nasi a slight scar, reminding one of a faded mucous patch.

He was placed on the mixed treatment for some time, and for a while there was an apparent improvement, which then ceased, and the eruption got worse. He was afterwards given DeValangin's solution, six drops three times daily. Under this he has steadily improved. The itching, which has been quite a marked feature off and on during the last few months, has about ceased, and there is a lessened formation and development of the tubercles.

When presented before the Society, almost the entire surface of the body was the seat either of cicatrices or of papules or tubercles in different stages. These latter were isolated from each other, of size varying from a very fine shot to large buck shot, or very small split pea, red, and quite solid to the feel. They invariably left scars, and each separate papulo-tubercle ran its course, if undisturbed, in two or three weeks.

At one time, as stated, the eruption so resembled a syphilide that the patient was treated several months for syphilis, with some improvement. At another time the itching was so great, and some of the elements presented the appearance of urticarial wheals to

such an extent, that the case was thus named. It was now presented for diagnosis.

DR. BRONSON remarked that he thought the eruption in this case was closely allied to chronic urticaria. It would seem from the patient's statement that the commencement of the papules was very similar to the usual development of the wheals of urticaria, and that the only essential difference was due to the longer persistence of the lesions in the present case. The apices of the tubercles were torn by the patient's nails, producing the slight blood crusting which gave the case a somewhat peculiar aspect.

DR. BULKLEY stated that at one time he had classed the disease as chronic urticaria, but found reason from the further behavior of the case to change his opinion. Upon the suspicion of a possible specific origin of the disease, the patient had at one time been subjected to a mercurial treatment for a few months, but with negative results. He was now improving under arsenical treatment.

In opening the discussion of the two cases of

### Venereal sores,

DR. FOX remarked that they differed in no way from cases daily met with. They were chiefly remarkable for their non-distinctive characteristics. The object in bringing them before the Society was to test the ability of the members to differentiate between the two species of sores, where the typical signs which usually serve to distinguish them are doubtful and obscure. In neither of these cases is there well marked induration, or characteristic glandular enlargement. The question is, can we, without applying the test of auto-inoculability, give a positive prognosis of these lesions?

DR. KEYES thought that it was perfectly easy to decide the character of a venereal sore before the appearance of secondary symptoms. In a majority of cases he would have no hesitancy in giving the prognosis of a sore, simply from its inspection and feel, without reference to other diagnostic marks, but in a few exceptional cases this is impossible. Dr. Sturgis's case he regarded as an indurated chancre; Dr. Fox's as simple chancroid. In this case not even a parchment induration could be made out.

DR. SHERWELL regarded Dr. Fox's case as indurated chancre, the other case as non-specific.

DRS. BULKLEY, CAMPBELL and PIFFARD coincided with Dr. Sherwell.

DR. FOSTER remarked that from a simple inspection of the sores, without feeling them, he would agree with Dr. Sherwell in his diagnosis.

DR. BRONSON regarded both cases as syphilitic. While the induration in neither case was of a pronounced type, he believed that nevertheless both were true indurations, representing something more than mere inflammatory thickenings.

DR. STURGIS thought that neither case was syphilitic. The presence of a parchment induration in either case was deceptive. The hardness was simply the result of irritation, merely an inflammatory thickening of the tissues. This hardness had perceptibly diminished since the patient had been under his observation. The glands, though indurated, were by no means characteristic.

DR. SHERWELL gave the following brief history, and exhibited a patient with supposed

### Pemphigus.

The patient, æt. 32; married 17 years; the mother of four healthy children. Disease first appeared in the spring of 1874, in the form of small spots upon thighs. These were red, elevated and covered with a scale, but were *not* bullous or moist in character. They disappeared in the fall and reappeared in the spring for three successive years. In the spring of 1877 a crop came out over the whole body, face and scalp, but worse on the extremities; they did not disappear in the fall. She was put under a mercurial course of treatment, and the eruption was made worse. Came under Dr. Sherwell's care two weeks ago. The eruption is composed of red, ovoid, circular, and elevated patches, with rupia-like crusts on some of them, of the size of one-half dollar. There are two or three bullæ on the fingers, and one on the toes, of recent occurrence.

DR. KEYES was disposed to class it as pemphigus. There was certainly evidence of a bullous character in some of the more recent lesions of the feet and hands.

DR. BULKLEY regarded it as pemphigus, and recommended the use of arsenic.

DR. PIFFARD thought it a case of non-specific rupia.

DR. PIFFARD called the attention of the Society to the variations in the formulæ for Asiatic pills. He had investigated the matter somewhat, and found that different preparations vary widely in composition. These pills enjoy such a high repute in Europe in the treatment of cutaneous affections that he had prepared a formula which he would recommend, viz.:  $\mathcal{R}$  Arsenious acid, 2 parts; black pepper, 20 parts; sugar of milk, 78 parts; mix thoroughly. This could be used in powder, or in the form of compressed pills.

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*Ninty-second Regular Meeting, March 26, 1878.*

The following cases were exhibited before the Society:

DR. SHERWELL presented a case *rodent ulcer*.

DR. SHERWELL presented also a case of *ichthyosis*.

DR. KEYES presented a case of *lupus erythematosus*.

DR. BULKLEY presented a case of *exfoliative dermatitis*.

DR. MORROW presented a case for diagnosis

DR. FOX presented a case of *fibroma*.

DR. FOSTER presented a case of *elephantiasis Græcorum*.

DR. STURGIS presented a case of *venera! sore*.

DR. SHERWELL exhibited a case of

### Rodent ulcer.

in which the disease had lasted ten years ; most excellent results had been obtained by treatment with perchloride of zinc and chromic acid.

DR. STURGIS regarded the case as one of *lupus vulgaris* ; he also differed in his estimate of the beneficial effects of treatment thus far.

DR. KEYES regarded the disease as different both from epithelioma and *lupus* ; he thought it belonged to a class of cases frequently encountered in practice, which, while presenting some of the characteristic features of one of these diseases, differed from both in many essential points.

DR. BULKLEY considered the disease in this case essentially the same as that existing in the second case which he had presented at the previous meeting. He regarded this lesion as epithelioma, it was certainly different from the soft, reddish tubercles, with adherent scales which characterize *lupus*, as exhibited in his first case at the last meeting of the Society. The pearly white tubercles in the present case he regarded as pathognomonic of epithelioma.

DR. SHERWELL presented a case of

### Ichthyosis,

in a girl fifteen years of age. The disease which had existed six years, made its first appearance on the feet.

DR. BULKLEY exhibited a remarkable case of

### Dermatitis exfoliativa,

recurring frequently upon both hands and both feet\*.

DR. KEYES recalled a case in which he had been consulted, where there was exfoliation of the skin, but not so extensively as in this case. There were exacerbations of the disease attended with febrile manifestations, but the attacks were not preceded by boils or any local disturbance.

DR. FOSTER thought the eruption might be associated with kidney disease, possibly glycosuria, in the relation of cause and effect.

DR. MORROW presented a case for diagnosis. The lesion situated upon the palmar aspect of the index, middle, and ring fingers, had existed for five years. About three months ago, the disease began to invade the palm of the hand. It had been treated as an eczema, but there was a suspicion of a possible syphilitic taint ; there were no other manifestations of disease on any other part of the body.

\*For description of case see page 226.

DRS. KEYES, PIFFARD, STURGIS and SHERWELL regarded it a case of eczema.

DR. BRONSON thought that while it resembled eczema there were several points which were suggestive of syphilis, especially the absence of itching and the apparent progress of the disease at the periphery, and healing in the center. He had been led into error in a similar case, which at first was treated as eczema, owing to the presence of itching, and the absence of perceptible infiltration of the border, but which later assumed the characteristic appearance of a palmar syphilide, and was readily cured by anti-syphilitic treatment. In both cases the hands were much exposed to the irritation incident to household duties, such as scrubbing and the like, and it was believed that the true features of the disease might have been masked by a certain eczematous character having been super-added to the original affection.

DR. BULKLEY regarded the case as undoubtedly one of late syphilis of the palm.

DR. FOX presented a case of

### **Fibroma.**

in an adult patient. The disease consisted of half a dozen or more, almond-sized, pedunculated tumors, situated in front of either ear. They had existed since childhood, and manifested no tendency to growth or development.

DR. FOSTER presented a patient with well marked

### **Elephantiasis Græcorum.**

He was a native of Connecticut, and had been a sailor; for ten years his trips have been between the West Indies and this port. The disease first commenced nine months ago; it was pretty generally distributed, but was especially developed about the head, giving the face quite a leonine aspect.

DR. BULKLEY remarked upon the fact that the patient was a native of Connecticut, and mentioned in this connection, two cases which he had seen, one in the practice of the late Dr. H. D. Bulkley, and one in his own, neither of which persons had ever been more than 150 miles away from New York. Both cases had been exhibited before the Society. Such cases occurring sporadically should be noted as valuable additions to the literature of the disease.

DR. SHERWELL called to mind a case in Brooklyn; the patient was Irish, and had never lived out of Brooklyn since his arrival from Europe.

DR. STURGIS brought before the Society, the case of

### **Venereal sores**

which he had exhibited at the last meeting. The only change which had taken place since then, had been the suppuration of the bubo in the left groin. The sore on the penis had cicatrized, but



marked induration was noticeable at its base. No constitutional manifestations had been made out.

DR. FOX said that his opinion in regard to the nature of the sore was unchanged. He thought that the subsequent history of the case went to confirm his diagnosis.

DR. KEYES was not inclined to change his opinion without another month of observation.

DR. BRONSON said that he was still of the opinion that the sore in this case was an initial lesion of syphilis. He would hold to this opinion even if no secondary symptoms manifested themselves. All cases of primary lesion are not necessarily followed by secondary manifestations.

DR. KEYES exhibited some fluid extract of the Chinese remedy for syphilis, "Tong pang chong"; also, Dupés' "pâte épilatoire," which he had found very serviceable for rapid epilation.

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*Ninety-third Regular Meeting, April 23d, 1878.*

DR. FOSTER presented a case of

**Dactylitis syphilitica**

of the right index finger, in a female child, æt. 3. No history.

DR. STURGIS observed that while there was no evidence in support of a syphilitic origin, he would suggest a tentative mercurial course.

DR. FOSTER replied that the patient had already been put upon anti-syphilitic treatment, since he believed that lesions of this character were not met with except as a sequence of syphilis.

DR. SHERWELL presented a case of

**Tinea versicolor**

of ten month's standing, in a male patient. The chief point of interest was its obstinacy to treatment.

DR. DAY remarked that the disease tinea versicolor seemed to occur idiopathically in underfed, ill-nourished people, and was very apt to recur on stopping treatment.

DR. PIFFARD was inclined to suspect some cachexia as being a source of the disease, and in this case he should look for syphilis. He had noticed that the patient had a post-cervical gland, high up, markedly indurated. He also called attention to the bearing of phthisis upon this disease. He believed that consumptive patients were specially liable to it.

DR. DAY had examined a very large number of phthisical cases, but did not see a greater average of cases of tinea versicolor among them.

DR. STURGIS concurred with Dr. Day with regard to the frequency of the affections in phthisical subjects.

DR. SHERWELL had seen this form of skin disease in the healthiest possible subjects, some of whom were robust country-

men, who had acquired the disease during the war. on the Potomac and elsewhere, and had suffered from it ever since. Most of them were readily cured by local measures.

DR. KEYES did not regard it as in any degree a symptom of phthisis or syphilis, though he always looked for some depression of the health or cachexia.

DR. FOSTER had seen it in apparently healthy individuals.

DR. PIFFARD referred to the extent and rapidity of development in the present case as pointing to some dyscrasia. He did not wish to be understood as saying the disease was evidence of syphilis or phthisis, but simply mentioned them as the two most prominent dyscrasiæ, and the most liable to promote the development of the parasite. He considered it always an index of depressed health.

DR. FOX had seen it in the healthiest people, but in those who sweat freely and neglect bathing and change of clothing. He regarded as the effective cause of the affection perspiration left long in contact with the skin.

DR. OTIS had never associated the disease with dyscrasiæ, and was certain he had seen it in healthy persons.

DR. BRONSON thought that the affection was not necessarily associated with any general impairment of health, but that in every case some local impairment of the integrity of the part must precede the development of the disease. The parasite could not affect a sound skin; the perspiration by long contact with the skin caused a maceration of the epidermis, and so injured the part as to render it unable to resist the invasion of the parasite. A cure to be effective and permanent required not only the use of paracitides, but treatment directed to restoring the entire health of the part.

DR. ROBINSON exhibited a case of

### Misplaced testis

in a child six weeks old.

DR. STURGIS thought that the testicle passed down along the course of the transversalis fascia, and had made its exit into the perineum.

DR. ROBINSON was of the same opinion.

DR. KEYES referred to cases recently reported in English journals of replacement of the testicles from the perineum into the scrotum.

DR. FOX showed a case of

### Keloid

of the face, in a female, aged 22 years. It had followed variola, which had occurred when she was 8 years of age. The keloid had been greatly improved by blistering, which had been begun in January.

DR. PIFFARD said that he had reported a case of keloid of

similar nature, following mentagra, which disappeared under the use of an irritating unguent, viz., iodide of potassium ointment.

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*Ninety-fourth Regular Meeting, May 25th, 1878.*

DR. CAMPBELL presented on behalf of Dr. Bulkley a case of

### **Lupus erythematosus,**

in a patient aged 72. The lady, Mrs. D., the wife of a physician, has always enjoyed good health, and is well preserved and active for her years. Five years ago a small scaly patch developed in the right eyebrow, which has remained there ever since. One year ago she noticed a small red spot on the left cheek, shortly another developed on the right cheek, and soon a third appeared on the end of the nose. These have remained ever since, with the formation of new ones, all possessing the same characters as those coming first. About two months ago somewhat similar patches appeared upon the front of the legs.

The present condition may be described as follows: The end of the nose is occupied by a patch of diseased skin, about the size of a nickel five-cent piece, of a coppery red color, with a roughened surface, upon which the openings of the sebaceous follicles may be seen, enlarged and filled with horny plugs. Upon the left cheek is another circular patch, with rather more scaling, the under surface of the scales having prolongations into the follicles. The right cheek has two similar patches, of about an inch in diameter, touching one another. There are also two or three other smaller spots, one on the pinna of the left ear, which is very characteristic of lupus erythematosus.

On the left arm are several circular patches, much more scaly, and recalling at once ordinary psoriasis. On the front of the right leg there are also several psoriatic spots, and one on the left calf. The eruption in these latter places is certainly of very recent origin; moreover it has yielded very rapidly to treatment on the arm and legs, and now there are but the remains of the former lesions, which certainly resemble greatly a fading psoriasis. The eruption on the face has not altered much under treatment, which indeed has been commenced but lately.

The peculiarly interesting features in the case are the appearance of lupus erythematosus in so old a person, and the close resemblance which it bears to psoriasis. If the eruption on the limbs be regarded as psoriasis, its late development for the first time in so old a subject is likewise remarkable.

DR. CAMPBELL also presented for Dr. Bulkley a patient with a

### **Pigmentary syphilide.**

It occurred in a female, aged 27, who had been under observation and treatment for six months. She first applied while the

chancre was well marked (although in a retrograde stage), on account of a small tubercular syphilide, which was pretty generally diffused over the body. This was the first skin lesion she had noticed, and occurred certainly within two or three months after infection.

The pigmentary syphilide was first noticed about a month ago, when it presented the same appearances as at present. On either side of the neck, extending almost from the head on to the chest, is a light brownish, dirty looking discoloration, with here and there white patches upon it, generally circular, but often irregular in shape. These have not the marble whiteness of leucoderma, nor are the borders more deeply discolored than the rest of the pigmented surface, as is the case in that disease. The white spots were not the seat of former syphilitic lesions, as had been suggested by Dr. Fox. The case had been watched almost from the beginning, and these had not any of the tubercular lesions on their site. The syphilitic eruption had yielded fairly to mixed treatment, but the patient was somewhat irregular in attendance; the pigmentary affair had developed while she was under specific medication. The case had been shown to a number of physicians at the New York Hospital, who recognised perfectly the pigmentary lesion as described by Hardy and Fournier.

DR. FOX said that while he regretted not being able to see the case by daylight, he thought from its appearance under gas light that it was unquestionably a case of the so-called pigmentary syphilide of Hardy and Fournier. His views on the nature of the lesion had been expressed in a paper read at a recent meeting of the Society.\*

DR. FOSTER thought that those pigmentations upon the neck might be due to nervous irritation, as in chloasma.

DR. CAMPBELL presented another patient for Dr. Bulkley, with

### **Hereditary syphilitic notched teeth and bone lesions.**

Edward B., aged 12 years, was always a delicate child, and had the snuffles in infancy, but his parents cannot remember any skin lesions upon him. His father states that the first disease which they noticed was when the boy was about 8 years old, when the uvula was found to be lost, by ulcerative disease; he had not complained of any pain in it previously. Very shortly the swellings of the bones began to manifest themselves, and these have remained and increased since. Three years ago the eyes became affected by a deep seated blindness (choroiditis?), which improved greatly under some treatment by medicine internally.

The father has now a well marked tubercular syphilitic eruption, also much occipital headache, great tenderness over the tibiæ, and an enlarged bursa on the left elbow. The mother is apparently free from eruption. She had had several healthy children

\*See Archives of Dermatology, April, 1878, page 135.

before the birth of this one. Her next conception ended in an abortion at five months, from no especial reason.

The boy is now seen to be delicate, pale and poorly nourished. He is very bright at school, but his eyes have never regained full strength, and he is now kept from school on account of them. His forehead is square, with frontal prominences at the sides; the bridge of his nose is sunken; the teeth exhibit most perfectly the lateral notching of the upper central incisors, with much antero-posterior thickening; they are also pegged shaped to a certain degree, and stand apart. The most marked bone lesion is on the right leg, whose tibia is twice normal thickness, and bent. The upper end of the left tibia is enlarged, and very tender. There are also enlargements on the humeral extremities of both radii, which are also tender. On the right forehead there is a large flat node, which is also painful. The mother states that the distortion of the right tibia has occurred slowly by the development of painful bony enlargements, which gradually lose their painful character, and leave behind them the permanent thickening. This has been observed several times during the six or eight months he has been under observation and treatment.

DR. MORROW again brought before the Society the case of

### Palmar lesions,

exhibited two months ago (see page 235.) The differential diagnosis between eczema and a syphilide was still doubtful. The condition of the hand had been much improved under simple treatment.

DR. BRONSON remarked that when the case was first brought before the Society, he had been unwilling to express a positive opinion, though inclining to believe that the disease was syphilitic. On now seeing the case again he had become convinced of its syphilitic character, and should not hesitate to pronounce it a syphilitic psoriasis. One or two well marked papules on the back of the fingers, the infiltration of the edges, the clearness of the centres, and the general form of the lesion, were characteristic features of syphilis. The fact that it had improved under simple treatment was no evidence of its non-specific character. There might have been an eczematous element present. He had seen eczema develop upon syphilitic lesions, but never eczematous lesions become syphilitic. If there had been two diseases in this case, the essential and primary one was syphilis.

DR. TAYLOR said that he would not give a positive opinion. The shape of the lesions and the papules on the back of the fingers made it suspicious, but it was often impossible to differentiate the two diseases from simple inspection.

DR. STURGIS remarked that while the appearance of the disease was suspicious, the history of the case pointed rather to an eczema than syphilis.

DR. FOX remarked that when he first saw the case at the Dis-

pensary, he thought it a case of syphilis. There certainly was a syphilitic history. The patient had stated that about the time the disease first made its appearance, she was delivered of a child, which had an eruption, and soon died. There seemed, indeed, to be an eczematous element present. He was now confirmed in his first opinion that it was syphilitic, and had no doubt that two or three weeks of mercurial treatment would entirely cure it. The characteristic outline, somewhat serpiginous in form, its creeping invasion, first extending from one finger to another, and then invading the palm, were evidence of its syphilitic nature.

DR. FOSTER said that he thought as he did when the case was first presented that it was eczema. The eruption was not, nor had it been, symmetrical, as we should expect were it syphilitic. The lesion was fissured, and the edges terminated abruptly. The absence of itching was no evidence, as it was frequently absent in eczema; and as to the papules, it was well known that the lesions of eczema were polymorphous.

DR. MORROW remarked that when the case first came under his observation he thought it syphilitic. The appearance of the lesions and the history of the case seemed to confirm this view. He had changed his opinion solely from the results of treatment. He did not think that a syphilitic lesion could be influenced so markedly by simple treatment. At the present rate of improvement, the patient should be well in another month.

DR. SHERWELL thought it an eczema.

DR. CAMPBELL thought it a syphilide.

## Digest of Literature.

### I.

#### DISEASES OF THE SKIN.

##### ANATOMY, PHYSIOLOGY AND PATHOLOGY.

A. R. ROBINSON, M. D.

**The minute anatomy of two breasts, the areolæ of which had been the seat of long standing eczema.** To determine the relation which exists between carcinoma of the breasts and long continued eczema of the nipples, DR. BATLIN examined two breasts affected with the latter disease, and found the galactophorus ducts widely open or distended. These structures were not lined by normal cylindrical epithelium, but contained large masses of squamous or glandular epithelium. In the immediate vicinity of the ducts the connective tissue was infiltrated with round cells. An induration in one breast presented much the same appearances as are found in some forms of mammary cancer. The acini were found larger than normal, filled with epithelium, and more widely separated than in health. *Med. Chirurg. Trans., Vol. 41.*

**Structure and growth of epithelium of the cornea and of the skin.** On this important question DR. CHARPY believes that regeneration of epithelium arises from cellular segmentation of existing epithelium, and that the connective tissue beneath only furnishes the nutritive material. He ascribes an independent existence to the epithelial layer from the period of its first formation in the embryo. (These observations of Charpy's agree with conclusions arrived at by myself when studying psoriasis, a disease in which there is rapid development of epithelial cells. The new cells were found to have their origin in division of the cells of lowest layer of the rete malpighii, and not from emigrated round cells.—*Rep.*) *Lyon Méd., No. 18, No. 20 and No. 22, 1877.*

**Microscopic study of the growth and change of the hair.** DR. EBNER regards the papilla and the internal sheaths as the fundamental elements which regulate the growth of the hairs. He also gives a theory as to the manner in which the hair is pushed towards the surface, but the explanation is not very clear. *Sitzb. der k. Akad. der Wissens. in Wien. t. 74, p. 339-394, 1876.*

**The cutaneous glands and their muscles.** From the position of the muscles to the sebaceous glands DR. HESSE believes that the former by contracting the glands assist in expelling the sebaceous secretion, and on this account are true gland muscles. *Zeitschr. f. Anat. und Entwickl.-geschichte*, No. 274, 1876.

**The termination of nerves in the corpuscles of touch.** RANVIER has studied the touch corpuscles in the tongue of the duck, and thinks the arrangement is the same as in the human finger, though the latter is more complex. In web-footed animals the corpuscles are composed of two, three, or four large cells disposed in a regular pile, one above the other, and enveloped by a common lamellar capsule. The axis cylinder enters the capsule, and divides into branches for each interval of superimposed cells. In this space the axis cylinder, or its branch of sub-division, enlarges, and forms a tactile disc of a nummular form, with round margins, composed of a substance apparently homogeneous, coloring in gray with osmic acid, and in violet with chloride of gold. The disc never extends beyond the margins of the two cells, between which it is placed, and which consequently surrounds and holds it. *Compt. rendus Acad. des Sciences*, Nov. 26, 1877.

**Numeration of blood corpuscles in skin diseases.** According to Malassez there are on an average 4,000,000 to 5,000,000 red corpuscles in a millimetre cube of blood in a healthy human being. In females the number is less, and they are also diminished in wasting diseases. DR THIN in making his observations selected persons in whom the blood was not affected by medicinal treatment or other diseases. He found that in psoriasis there may exist a high proportion of blood corpuscles. In one man, aged 25 years, there were 5,250,000 per mm. cube. In eczema the number was about normal. Dr. Thin's observations show that profound blood disease is not a necessary accompaniment of many skin diseases. *Royal Med. and Chirurg. Soc., Lancet*, p. 175, Jan. 26, 1878.

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## INFLAMMATIONS; ACUTE AND NON-CONTAGIOUS.

JAMES C. WHITE, M. D.

**Erythema nodosum.** DR. SÜSSMANN communicates a case of this affection in a girl with dysmenorrhœa, in which the eruption was accompanied by evening paroxysms of chilliness, of half an hour's duration, and by fever, which lasted until the next morning. The disease was not controlled by quinine, and ran a course of fourteen days. *Berliner Klinische Wochenschrift*, No. 4, 1878.

**Treatment of intertrigo in infancy.** DR. WERTHEIMER, of Munich, in an article upon this subject, strongly recommends the use of a solution of corrosive sublimate (0.05 in water, 100), applied upon cloth for an hour three or four times daily. He has never seen any effects from absorption. Black wash will affect the speediest cure, with still less danger of absorption. *Deutsche Archiv. für Klin. Medicin*, Band 21, Heft 203.

**Treatment of rhus poisoning.** DR. BROWN, U. S. N., Mare Island, Cal., believes that he has discovered in bromine a "specific" cure for the cutaneous inflammation produced by contact with the volatile poison of this family of plants. He states that he has used the remedy in forty cases, with the same unvarying success; that the eruption never extends after the first thor-

ough application, and promptly begins to diminish, the patient being entirely cured in twenty-four hours, if the application be persisted in. He uses the bromine dissolved in olive oil or cosmoline, ten or twenty drops to the ounce, rubbing it gently upon the affected parts three or four times a day, and washing off the oil twice a day with soap. There is no pain attending its use. The bromine is so volatile that it is necessary to prepare the mixture afresh every day. [A fair definition of the common phrase, "newly discovered specific remedy," would be—something soon forgotten—and their brief reputation is generally based upon their supposed action in affections, which, like rhus poisoning, are mainly self-limited in their course. California offers, however, abundant opportunity for testing the merit of remedies in this disease, and the position of Dr. Brown warrants a fair trial of his discovery.—*Rep.*] *N. Y. Med. Record*, April 20, 1878.

**Urticaria.** DR. H. CUNDELL JULER, of Cincinnati, contributes a long article on this "most fantastic" of cutaneous diseases, describing the various forms it exhibits very well, and giving the history of a case of urticaria tuberosa. The etiological portion of the article is somewhat fanciful, as is likely where so little positive knowledge exists. *Cincinnati Lancet and Observer*, January, 1878.

**Intermittens urticata.** DR. WARSCHAUER, of Krakau, reports, under this title, a case of intermittent fever, in which the attacks were accompanied by outbreaks of urticaria. With the fourth and last, the disease yielding rapidly to large doses of quinine, the paroxysm was slight, and the cutaneous disturbance the more prominent. Another case of this rare complication was reported by Prof. Zeisel, of Vienna, in the same journal (No. 46, 1877), in which fourteen out of the seventeen paroxysms of fever were accompanied by urticaria, the latter always disappearing during the intervals. Dr. W. does not feel warranted to offer such concurrence as evidence that both affections are vasomotor neuroses. *Allgemeine Wiener Medizinische Zeitung*, 1878, No. 9.

**Treatment of carbuncle.** MR. WARD proposes the following plan for the treatment of carbuncle: To make an incision about an inch and a half or two inches long, as the case may be, over the centre of the carbuncle when the slough has formed, and from four to six counter-openings round the central one, varying in size from a quarter to half an inch. Then plug the openings with strips of lint steeped in some stimulating application, and lay a poultice over all, dressing the carbuncle in the same way every day, until all the sloughs have separated. The advantages which he claims for this method are: 1st, and most important, all the integument is preserved; 2d. It has all the advantages of the mode of treatment by crucial incision, without any of the disadvantages of that method; 3d. There is almost entire freedom from hemorrhage; 4th. The avoidance of a large,

open, suppurating sore; 5th. Just sufficient space for removing the dead cellular tissue; 6th. Very slight cicatricial marking. *Dublin Journal of Medical Sciences, No. LXIX.*

**Frontal herpes, angina, death.** M. COUYBA reports the case of a man, 65 years old, who three years previously having been affected with a left frontal herpes, followed by persistent neuralgia, was attacked by an eruption of large vesicles upon the same part, with very violent neuralgic pains along the frontal nerve, and intense and deep seated pain in the eye. There were purulent vesicles upon the lower palpebral conjunctiva. Deglutition was painful, and the pharynx and tonsils were very red, but without eruptions. On the fifth day there was paralysis of the muscles of the pharynx and dysphagia; on the seventh asphyxia and mucous rales in the lungs; on the tenth death ensued. *Union Médicale et Scientifique du Nord-est., 31 Decemb., 1877; from Journal de Médecine et de Chirurgie pratique.*

**Bilateral herpes.** DR. JAMISON reports a case of this rare affection. The patient was attacked by nausea and vomiting, accompanied by severe pain in the head. Four days afterwards red patches appeared on the face, neck and arms, and shooting pains came on in the chest and between the shoulders. On the forearms the eruption became confluent to such an extent as to cover the outer surfaces continuously. Pressure on either side of the spine, in the cervical and upper dorsal regions, caused severe pain. The eruption, which did not extend upon the chest below the second rib, dried up in about three weeks, but the pains in the back and chest, which were neuralgic, were more persistent, recurring for a month longer. The seat of the eruption corresponded to Hebra's zoster faciei, nuchæ and brachialis. *London Med. Record, Jan. 15, 1878; from Australian Med. Journal.*

**Herpes zoster, produced by pressure upon the nerves.** DR. JONES reports two cases of zoster, in which he believes that the eruption was caused by pressure on intercostal nerves. In the first case a prominence was found on the sixth rib (a node). The patient was given mercury and iodide of potassium. When next seen there were copious and distinct crops of vesicles, showing the course of the intercostal nerve. The eruption continued until the prominence subsided. The second case was a man with an abscess forming in the bend of the knee. Hot fomentations were ordered. Two days afterwards there appeared copious and distinct crops of vesicles along the outer half of the calf of the leg, two large crops on the outer side of the tendo achillis, and a slight efflorescence upon the two outer toes. On opening the abscess the herpes disappeared. *Philadelphia Med. Times., Jan. 19, 1878; from British Med. Journal, December 1, 1878.*

**Pemphigus neonatorum.** DR. CÄSER BÆCK, of Christiania, reports a rare case of this affection, which ran an acute and rapidly

fatal course. The eruption showed itself on the fifth day after birth upon the neck, in the form of small vesicles, which spread rapidly over the whole surface of the body, the epidermis being elevated by a sparse, serous exudation, and giving rise to extensive excoriations, without any regeneration of the cuticle. The child died after an illness of nine days. An examination of the skin after death showed the vessels of the corium enormously enlarged, and filled with blood. There was no cell infiltration along their course. The case resembled one of pemphigus foliaceus in adults in appearance. *Viertelj. für Derm. und Syph.* V. Jahrg., 1 Heft.

**The relations of pemphigus to the neuroses.** MERMET, in his *Thèse de Paris*, 1877, in which a great number of clinical facts are presented, formulates the following conclusions: 1. Pemphigus is an inflammation of the skin which occurs in a great number of affections; 2. It is met with sometimes in the neuroses, and particularly in hysteria; 3. In the neuroses it has an irregular distribution, and is fugitive; the bullæ, containing a clear and slightly yellowish fluid, do not leave cicatrices. The outbreaks often alternate with the symptoms of the neurosis; 4. The prognosis is not grave; 5. Any slight irritation of the skin, which produces no effect in a healthy person, rapidly develops it in those affected with neuroses; 6. It is probably due to an irritation of the sensitive nerves at their origin in the gray substance of the nervous centres; 7. Its local treatment is the same as in the other varieties. *Annales de Dermatologie et de Syphiligraphie*, Tome 9, No. 102.

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## HEMORRHAGES AND NEUROSES.

ARTHUR VAN HARLINGEN, M.D.

**A case of peliosis rheumatica.** DR. W. T. TAYLOR'S case is interesting, with reference to the asserted nervous origin of purpura. He was called to see a woman 46 years of age, who had been in poor health for several years, experiencing occasional severe attacks of gastritis. The patient was found to be suffering the most acute pain, deep seated, burning, continuous, accompanied by an eruption of dorso-abdominal herpes zoster, involving the left groin also. The pain lasted two or three weeks after the disappearance of the eruption, and then decreased, while the nerves of the thigh, leg and foot became involved. Three or four days after the nervous affection attacked the leg, the foot and ankle of the affected side suddenly became swollen, œdematous, and very tender to the touch, particularly in the neighborhood of the joint. The

next morning a purpuric eruption could be observed about the ankle, which became less swollen, but was still painful, the pain apparently locating itself in this region thenceforward. The eruption soon began to fade away, but a relapse took place, accompanied by the same symptoms, preliminary swelling, etc., and a series of relapses occurred with the same interval between, the eruption mounting higher with each relapse, until the entire leg became involved, and the affection lasting in all about seven months. Toward the last the joints of one hand became stiff and swollen, but this passed away within a few days. Examination of the heart showed mitral regurgitation. *American Practitioner*, 1876, p. 333.

**Purpura variolosa.** At a recent meeting of the Dublin Pathological Society, DR. NIXON exhibited specimens taken from a man, who had died in the hospital under the following circumstances: The patient had had repeated chills for two days, but no pain in the back nor vicinity. On the third day, a red rash made its appearance over the backs of the hands and forearms, also extending over a small portion of the chest. He had sore throat. By the fourth day the rash had extended over the entire trunk; it became dark purplish in color, and large purpuric patches with petechial spots showed themselves chiefly on the lower part of the abdomen, and about the knees, but also on the back. His conjunctivæ were injected, tongue thickly coated, temp. 103.2°F., pulse 130, resp. 32. While the patient's face was much swollen there was no rash upon it. On the sixth day he was seized with vomiting of blood and melœma, his strength seemed unabated. On this day he asked for water and drank freely. He then suddenly complained of an agonizing pain across the front of his chest "as if his heart were breaking," sank forward and in a moment was dead. Post-mortem examination showed the integument of the dependent portions of the body infiltrated with blood, so as to be of quite a bronze color. The blood was remarkably fluid and intensely black in color. Apex of right lung softened, infiltrated with blood, and granular on section. Heart contracted. No blood in any of the cavities. Liver apparently in a state of fatty degeneration. Spleen and kidneys apparently normal. Spinal cord not examined. Perhaps the most interesting point in the case, was the condition of the liver, which in *p. variolosa*, as Curschman has pointed out, resembles the appearance presented by the fattily degenerated liver in phosphorous poisoning. *Dublin Four. Med. Sci.* 1877, p. 343.

**A retrospective study of Werlhof's disease.** DR. LASEGUE, the well-known editor of the *Archives Générales*, gives an account of the affection unusually known as purpura hæmorrhagica, or Werlhof's disease. Werlhof's title to be remembered by this affection, rests on the rather scanty notes of a single case, which however, is certainly well described. LASEGUE's article which in part histori-



cal, in part clinical, traces the history of our knowledge of p. hæmorrhagica down to the present century, and gives some facts designed to show forth the distinctive signs by which it is to be distinguished from the purpura of scurvy. *Archives Gén. de Méd.*, 1877, T. I., p. 586.

**Cases of purpura rheumatica or hæmorrhagic rheumatism.** DR. REGINALD SOUTHEY gives the case of a man who suffered from a purpuric eruption over the chest, abdomen, legs, etc., some bullæ, containing a sanguineous puriform fluid, on the knuckles. There was some increase in temperature, articular and epigastric pains, a systolic apex murmur over the heart, blood and albumen in the urine, vomiting and constipation. The case ended fatally, presumably from the heart trouble, but there was no post-mortem examination. SOUTHEY takes his own case and others which he relates, and which were considered by the physicians reporting them p. rheumatica, to be a variety of rheumatism, which either occurs in the subjects of chronic nephritis, or is sooner or later complicated by an acute renal affection. The leading features of these cases are a purpuric rash, hæmorrhagic tendency and hæmaturia, the latter being prone to terminate in fatal nephritis. [SOUTHEY'S case does not resemble those of p. rheumatica in their characteristic features, and his account of the cases of other observers is not full or distinct. He thinks Duhrings' cases may be syphilitic papular eruption, (!) and has apparently overlooked Kinnicutt's well-known paper published in the *Archives of Dermatology*, April, 1875.—*Rep.*] *Lancet*, V. I., 1878, p. 6.

**Remarks on rheumatic purpura.** DR. ROBERT LIVEING gives very brief notes of a case of relapsing erythema with purpura and rheumatic symptoms, and adds to this some remarks on the existence of the affection known as p. rheumatica. LIVEING thinks that under this name have been grouped, cases of genuine scurvy, purpura occurring in the course of grave disease of the heart, kidneys, etc. Excluding these, there are cases which cannot in his opinion, be separated from the symmetrical forms of erythema, (e. papulatum. e. nodosum, etc.) The symptoms are all alike; there is slight constitutional disturbance, articular pains, and sometimes redness and swelling about the joints, with purpuric spots on the skin, either with or without distinct patches of erythema. Usually within a few weeks or months, all these symptoms disappear and the patient is well. Between this not very uncommon affection and symmetrical erythema, he can find no line of demarcation whatever. LIVEING considers Southey's case, above noted, as one of purpura, occurring in the course of heart and kidney trouble, and not one of p. rheumatica. *Lancet*, V. I., 1878, p. 308.

**The various forms of pruritus cutaneus.** DR. R.W. TAYLOR in a paper read before the Burlington (Vt.) Medical and Surgical Club, arranges the chief causes of pruritus, (considered as an entity, and not merely a symptom of other affections), under five

heads, as follows : (1) That itching which is caused by external agents, as rough clothing, woollens, harsh friction, (such as with towels,) certain soaps and baths, and also vegetable and animal parasites. (2) Pruritus from internal causes, such as Bright's disease, gastro-intestinal, hepatic, pulmonary, and malarial affections; also, from plethora, and from that condition of sub-oxidation evidenced by such solid matters in the urine, as urea, uric acid, and oxalate of lime, which is found in the gouty and rheumatic diathesis or alone, as a morbid condition. Diabetes and certain nervous disorders, and tumors in the brain and cord, may also be mentioned under this head, as causes of pruritus. (3) The pruritus which follows certain diseases of the skin, themselves being attended most frequently with itching and burning combined with itching. Such are, urticaria, eczema, etc., etc. (4) Pruritus caused in great part by the structure or conformation and condition of the parts involved, such as, pruritus vulvæ, pruritus ani, pruritus of the scrotum, and femoro-scrotal pruritus; these may also be induced or perpetuated by other causes. (5) Pruritus of old persons, in which there may or may not be some visible lesion of the skin; sometimes there is well-marked atrophy; also that itching of certain parts, which from its development every winter has been named by Duhring, pruritus hiemalis. Finally, certain drugs, notably opium, induce cutaneous pruritus.

The chief importance of these facts consists in indications which they suggest for the treatment of internal conditions, as well as for the removal of the causes which are ascertained to be in operation. DR. TAYLOR gives a general sketch of the sources of pruritus, and suggests means, usually removal of the cause when ascertained, for their abatement. Proceeding then from the discussion of general remedies to the consideration of topical treatment, DR. TAYLOR offers a rich and varied store of recipes, suitable to every conceivable form of pruritus. Baths, followed by sedative inunctions, lotions of various kinds, as well as powders, injections and washes for vaginal pruritus follow each other in bewildering profusion. Most of these formulæ, it is proper to say, have been employed successfully by DR. TAYLOR, and go forth, so to speak, with his imprimatur. We have not space for more than one of these, a compound narcotic vinegar, of powerful anodyne effect, which is composed as follows :

R	Fol. beladonnæ	
	Fol. hyoscyami	ââ jj
	Fol. aconitii	j
	Acid acetic	3 viij M

The leaves must be reduced to a tolerably fine powder, and then mixed with the acid and allowed to macerate two weeks. When ready it forms a heavy dark colored liquid of pungent smell. Of this, two fluid drachms to the gill of water makes a very efficacious anti-pruritic, and a greater strength even may be used. The power of this lotion is sometimes increased by the addition of two

drachms more of acetic acid. *Archives of Clinical Surgery*, Aug. 1877.

**Trophic changes following lesions of the nervous apparatus.** DR. G. V. POORE, includes lesions arising from both disease and injury. After discussing the wasting and degeneration of muscle, together with congestion and vascular disturbance, he goes on to speak of trophic changes affecting the skin and mucous membranes, resulting in bed sores, loss of finger nails, shedding of epithelium, ulceration of the finger tips, cornea, and also eruptive changes in the skin. These changes never occur unless sensation has been abolished; they never occur in purely motor paralysis; nor are they due to the loss of protection afforded by sensation. Charcot's theory of nerve irritation as the cause of these various trophic changes, a theory which has lately found favor, does not seem to DR. POORE adequately supported by facts. The theory which appears to him more plausible is that in these cases of trophic changes affecting the skin, as a result of nerve injury, the effect is perhaps due to the fact of the part having been cut off from the possibility of reflex stimulation. Zoster, for instance, is perhaps the first symptom of a chronic destructive process, which merely acts by impeding the progress of those centripetal impressions which seem essential to healthy nutrition. *Lancet*, V. I., 1877, pp. 713-751.

**Symmetry in skin affections.** Under this title, DR. TESTUT, describes in a recently published brochure, the relation of the nervous system to diseases of the skin. The work is divided into two parts, the latter being concerned with "the solidarity of homologous regions and double organs." In the first, or dermatological portion of the work, M. TESTUT calls attention to the symmetrical character of skin affections, bringing forward illustrative cases. Passing successively in review the various diseases of the skin, he begins by a short clinical description, and cites in each instance a number of cases in which the lesion manifested itself in a symmetrical form, whether the two sides were simultaneously or successively affected. Even zoster, usually regarded as essentially unilateral in its occurrence, is shown by numerous illustrations to manifest itself symmetrically. M. TESTUT has drawn his inspiration in one respect from Rendu's writings, reviewed in this journal, (Vol. II, p. 76), from which he extracts a number of illustrative cases. He examines the nervous troubles which accompany the various skin manifestations, and thus prepares the conclusion to which he desires to arrive, viz.,—that this symmetry is accounted for, by the action of the nervous system in the pathogeny of cutaneous affections. M. TESTUT is occasionally carried away by his theory, as where he gravely brings forward cases of symmetrical professional eczemas, *e. g.*, "grocer's itch," to prove nervous influence. In a later chapter, M. TESTUT reviews the subject under the caption, "general pathogeny of skin affections," bringing to his aid three

orders of evidence. 1. Clinical observation. 2. Necropsies. 3. Physiological experimentation. As regards the latter, none are forthcoming, at least no skin disease has been produced by physiological experiment. Necropsies have only been successful in proving nervous lesions in zoster, so that the evidence is mostly confined to clinical observation. One of the most interesting chapters, is that on the influence of the nervous system in the production of purpura. The author attributes great influence to the vasomotor nerves, rejecting the existence of the "trophic" nerves, strictly so called. The mode of influence of the trophic nerves is usually reflex. The dermatological portion of the work is concluded by an examination into the conditions governing the bilaterality and symmetry of skin diseases. Diseases of the skin are either central in their origin, or peripheric. The peripheric are either systrophic from a bilateral excitation, as in the "grocer's itch" above mentioned, or from a unilateral excitation, illustrated by cases in which a wound of the brachial plexus on one side, is followed not only by an erythematous eruption and eczema of the corresponding, but also of that of the other side. Abstract in *Annales de Dermatologie et de Syphiligraphie*, T. 8, p. 385.

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## II.

## SYPHILIS AND VENEREAL DISEASES.

## SYPHILIS OF THE MOUTH, THROAT AND LARYNX.

GEORGE M. LEFFERTS.

**Syphilitic laryngitis.** Some of the practical points in LENNOX BROWNE's excellent article are as follows :

The larynx is affected in secondary syphilis at any time from six months to two years after exposure to the primary infection. It may occur either as an extension from the pharynx, or, as is more commonly the case, it arises at a somewhat later period, and independently of the pharyngeal manifestation. The truth of this last suggestion is evidenced by the facts that the larynx is often first affected after the disease in the pharynx has been cured, or without the latter ever having suffered, and also that the characteristics of secondary inflammation in the larynx are by no means so differentially distinctive as are those in the fauces.

Secondary syphilis in the pharynx is almost invariably accompanied by cutaneous manifestations ; whereas, if the latter have ever been noticed, they will often have disappeared months before the larynx is affected.

Mucous deposit, also, is by no means a natural product of syphilitic inflammation occurring in the larynx, nor is such inflammation or such deposit invariably, or indeed usually, symmetrical. Loss of tissue is rare, ulceration seldom extending beyond erosion of the epithelial layers, which occurs at points likely to be subjected to irritation from the passage of food or from mutual contact.

Condylomata occur in some situations, and they are probably not so uncommon as Morrell-Mackenzie (Reynolds's "System of Medicine") has estimated (4 per cent.). The author's experience would lead him to say about 10 per cent. as the proportion, but possibly he gives a longer limit to the secondary stage of the laryngeal disease.

Contrary also to the same authority, the author has seen not a few cases in which condylomata have developed into formations which were, to all intents and purposes, warty growths ; nor can he agree that such formations have in the larynx, any more than upon the skin, where *irritation is constant*, a tendency to spontaneous subsidence. All secondary syphilitic affections of the larynx are characterized, as are those associated with the same dyscrasia in other organs, by rapid amelioration under appropriate treatment, but by an equally strong tendency to relapse. This fact is often of great diagnostic value in doubtful cases of chronic laryngitis.

**TREATMENT.**—*General.*—A mild mercurial course is naturally indicated, and is most serviceable. The Turkish bath, followed by the calomel vapor-bath, or by moderate mercurial innunction, is of great value both for its general and local effects. Whenever conylomata appear, or there is any symptom of ulceration, iodide of potassium, with or without mercury, is indicated.

*Local.*—Stimulating inhalations of creosote, benzole, or pine-oil, as recommended in simple chronic laryngitis, are of the first importance. External applications of tincture of iodine, or mercurial ointment with iodine or belladonna, have a decided local beneficial effect.

Topical applications to the larynx are of even greater value than in simple chronic congestion, and must be pursued with proportionately greater regularity and perseverance, even after the inflammation has disappeared from the local cords. Allusion has already been made to the absence of warrant for the traditional preference of the profession for nitrate of silver in laryngeal disease. This remedy should only be applied when there is actual ulceration. Solutions of chloride of zinc (10 to 30 grains to the ounce) and of sulphate of copper (5 to 20 grains) are most useful as local applications in secondary inflammations, alternation of the solutions frequently having a great effect in promoting the cure. In very obstinate cases, spa-treatment at Aix-la-Chapelle or Bag-nères de Luchon may with advantage be prescribed.

*Hygienic and Dietetic.*—The indications are, to give rest to the voice, and to avoid exposure to all catarrhal or irritative influences.

Tertiary syphilis is characterized by ulceration of the most destructive character, causing permanent loss of tissue, followed by resulting cicatrices, which may either produce great narrowing of the larynx, or may be accompanied by new deposit having the same effect.

It occurs in the throat as one of the latest manifestations of the disease, and is often seen 20 or 30 years, or even at a still later period, after the primary infection. It may commence as an extension of the disease from the fauces, in which case it very seldom indeed advances beyond the epiglottis; and, under these circumstances, there is neither much thickening nor displacement, nor any great amount of trouble in the performance of function.

From the velum, or posterior wall of the pharynx, the disease very seldom descends into the larynx, and cases may frequently be seen in which the whole posterior wall of the pharynx is the seat of deep ulceration, extending upward into the naso-pharynx, but in which the larynx is absolutely free from any sign of ulceration, and in which, although articulation is affected, the tone-quality of the voice is unaltered. These remarks hold good also with respect to congenital syphilis, which it is not common to find in the larynx. The author, however, remembers a case seen some years ago, in which it appeared possible to believe that the patient, a young man

of twenty-two or twenty-three, was the subject both of congenital syphilis and of the same disease in the acquired form. His father was under treatment for tertiary laryngeal manifestations ; and the younger man, with characteristic teeth and physiognomy, and with cloudy corneæ, had been under medical care for palatal ulceration ; acknowledged to the primary infection, had the scar of a chancre, and some years after his first appearance as a patient he suffered from syphilitic invasion of the larynx.

It is not easy to affirm that the ulcerative process is always the result of degeneration of gummatus deposit, since the patient frequently does not come under observation until loss of tissue has already taken place ; but from the appearance of those ulcers, which are the undoubted sequelæ of gummata, it seems probable that such is the usual origin of laryngeal tertiary ulceration. The epiglottis, subjected as it is to greater irritation than any other part of the larynx, is the portion most frequently attacked. But it cannot be said that any one part is more prone than the rest to the destructive process.

**TREATMENT.**—*General.*—During the active stage of ulceration, the administration of the iodide of potassium or sodium is in the highest degree beneficial. Seeing, also, that the majority of the worst cases occur in very poorly-fed persons, cod-liver oil and iodide of iron are of great therapeutic value. In other cases, the iodide may be occasionally remitted, and cinchona with ammonia or acid substituted. When the ulcerations are healed, the preparations of mercury must be given for a lengthened period, as prophylactic against future attacks.

*Local.*—There is no better topical remedy for syphilitic ulcers than nitrate of silver, which must be applied *daily* with the aid of the laryngoscope. If there is much coating of secretion over the ulcer, it should be first removed by means of a soft, moist brush, or a piece of cotton wool in a suitable holder. When the ulceration is of the epiglottis, the galvano-cautery acts more rapidly in arresting the destructive process than even nitrate of silver.

Laryngeal œdema must be met by the prompt performance of tracheotomy ; and the same step may be necessary, at least as preliminary to later measures, if stenosis becomes extreme.

With respect to the further treatment of this last condition, it cannot be said that any great success has so far followed attempts to remove the cicatricial web, or to dilate the narrow orifice by bougies or analogous measures. It is better, therefore, to warn the patient on whom tracheotomy has been necessary, on account of such a condition, that he will in all probability be obliged to retain the canula for the rest of his life. The tube should always be inserted in the lowest point possible in the trachea, and should on no account be removed, however favorable the symptoms may appear, unless laryngoscopic examinations give evidence that the physical obstruction is lessened.

At a very early period after tracheotomy, it will be well to make



an opening in the superior surface of the canula, and to allow the patient to wear a pea-valve, so as to favor a natural process of dilatation by means of the current of air.

With reference to other operative procedures, the author would not recommend—at any rate for this disease—either resection of the anterior portion of the larynx, as practised by Heine, or excision of the extirpated vocal organ, as performed by Billroth and others.—*Louisville Med. News*, Jan. 19, 1878.

**Syphilitic laryngitis.** DURET, in the course of a review of M. Isambert's work on "Syphilitic Laryngitis," suggests the following methods of treatment: The general treatment should consist in protiodide of mercury in pills ( $\frac{1}{4}$  to  $\frac{1}{3}$  grain three times a day), or bichloride in solution. Should the affection have passed the secondary stage, iodide of potassium may be employed, or, in stubborn cases, the "mixed treatment." Tonics—iron, quinine, etc.—are usually called for. The patient should carefully avoid catching cold, and should avoid the use of tobacco and alcoholic liquors. Complete repose on the part of the organ itself is absolutely essential. The local treatment is of great importance. In the early stages, when there is only congestion or superficial ulceration, it should consist of insufflations of powdered alum, tannin, nitrate of silver, or, better still, spray of carbolic-acid solution, or solutions of alum, acetic acid, sulphate of zinc, etc. When the laryngoscope shows ulceration, the local treatment should be more precise and energetic. Cauterization at the seat of the ulceration may be practised by means of a small sponge moistened with tincture of iodine, solution of nitrate of silver, or of sulphate of copper, 1 to 30; of alum, 2 to 30; of sulphate of zinc, 1 to 100. These substances are preferably to be dissolved in pure glycerine; the crayon of nitrate of silver, or sulphate of copper may also be employed. Experience has shown that excessive inflammation and œdema of the glottis are not to be feared with this treatment. Isambert has obtained excellent results in obstinate cases by the use of chromic acid (1 to 8 and 1 to 5), which modifies the pathological tissues advantageously. When necrosis of the cartilages sets in, a practised surgeon may sometimes succeed in preventing extension of the injury by cauterizing the diseased points by means of the galvano-cautery. Dr. Masson, in his thesis (Paris, 1875), has given the indications for tracheotomy with great exactitude. The surgeon may be called upon to perform this operation on account of asphyxia from œdema of the glottis, gummy tumor, or vegetations obliterating the air-passages, abscess) inflammatory swelling, or obstruction by loosened portions of necrosed cartilage.

When asphyxia comes on progressively, Isambert recommends cauterizations by chromic acid (1 to 3), thus crisping the swollen tissues, giving access to the air, and sometimes influencing the disease favorably at the same time. He reports two cases cured in this way. The patient must, however, be carefully watched,

and if relief be not gained, it will be necessary to operate. When the progress of the asphyxia is sudden, tracheotomy is to be performed at once, even when the patient is *in extremis*. M. Trélat reports 76 recoveries in 100 cases of tracheotomy in œdema of the glottis from syphilitic laryngitis.—*L'Année Méd. de Caen et du Calvados*, Nos. 8, 9 and 10, 1877.

**Syphilis of the epiglottis.** KLEMM claims that the epiglottis is more generally and more seriously affected in syphilis than is commonly supposed ; and although it is less frequently involved than either the pharynx or the mouth, or especially the larynx itself, still, in many cases it is entirely overlooked, because its condition gives rise to no symptoms which lead to a laryngoscopic examination, or its prominent one—pain in deglutition—is ascribed to other causes. Syphilis of other parts of the larynx declares itself early in the disease by hoarseness, cough, etc., and attracts the physician's attention ; but syphilis of the epiglottis not unfrequently passes unnoticed by the patient, so long as the disease remains localized. It can therefore make much progress before it receives the attention that it demands, and he recommends most strongly that a laryngoscopic examination should be made in every syphilitic case that complains of pain in swallowing, even though there be no hoarseness, for otherwise ulceration of the epiglottis can be easily overlooked. Several forms of the affection are described by the author, and some are illustrated by drawings. In general, he states that the epiglottis is alone affected but seldom ; that, sooner or later, the disease will seize upon it ; that changes in its configuration are common ; that the commonest and most important symptom is pain in deglutition, much less marked, however, than is met with in laryngeal tuberculosis, and is a symptom whose cause, whether pharyngeal or laryngeal, needs to be differentiated—if the latter, pain will be less than in the former. The period of the commencement of the epiglottic affection, and its duration, vary within the widest limits. Rarely does it appear within the early years of the constitutional disease. Usually the patient has long suffered from syphilis, and three to six years after the primary infection will elapse ; it belongs to the later symptoms of the disease, and has their general characteristics—a slow progression, and resistance to remedial agents. Mistake in diagnosis can occur in spite of the most careful examinations. A syphilitic epiglottis can easily be mistaken for cancer, especially when it is much swollen and ulcerated. In such a case, the clinical history of the patient, and the presence of other evidences of syphilis in the pharynx, larynx, on the skin, etc., will be of great assistance. Tuberculosis of the organ presents even greater difficulties. As a rule, the swelling in tuberculosis does not reach such a grade as in syphilis, and the granulations are flatter. Moreover, an examination of the lungs is conclusive. The emaciation, loss of strength, cough, and expectoration, may be very deceptive, as is proved by

one of the cases whose history is appended to the article, which turned out to be syphilis, and not tuberculosis of the larynx.—*Archiv. für Heilkunde.*, Dec. 10, 1877.

**Pathology and therapeutics of nasal syphilis.** SCHUSTER's paper is a well-written and interesting one, and forms a valuable contribution to our knowledge on the subject of nasal syphilis. The cases upon which it is based have been carefully worked up, are reported in full, and the deductions drawn from them are, therefore, entitled to consideration. The microscopical examinations of morbid structures pertaining to some of them have been made by Dr. Sängcr, the assistant in the pathological laboratory at Leipsic, and are fully illustrated in the lithographic plate which accompanies the article. The paper opens with a short review of the recent literature of the subject, the views in general of Schede, Volkmann, Hamilton, Michels, Diday, Störk, Michäelis, and Bardenheuer, being given: then follows the detailed history of cases, those being first given in which no microscopical examination supplements the clinical details; finally, the analysis of the cases presented, and the general deductions. As regards treatment, Schuster's experience has convinced him that Volkmann's procedure (removal of morbid tissue and necrotic bone by means of a sharp spoon-like instrument), together with careful watching for months, and thorough general treatment, will save the nose from deformity.

Some general directions regarding this plan of treatment are given, but for special details the reader is referred to the works of Schede and Volkmann.—*Vierteljahresschrift, für Dermat. u. Syph. Jahrg. IV., Heft. I. & II.*, 1877.

**On syphilitic narrowing of the larynx.** In a recent paper, DR. SOMMERBRODT, of Breslau, strongly opposes the statements of Kaposi regarding the extreme painfulness of syphilitic ulceration of the larynx. He rather regards the almost entire absence of pain in laryngeal ulcers as diagnostic of syphilis, seeing that cases have often occurred where the entire epiglottis was destroyed by ulceration, while the patients complained of little more than discomfort in the throat; or that, in cases of cough and supposed lung-disease, the only discoverable disease consisted of a deep ulcer and defect of the epiglottis; or lastly, that, with extensive ulcerations of the vocal cords, the only symptom was a certain rough hoarseness of the voice. On the other hand, he regards exquisitely painful ulceration of the larynx and epiglottis as pointing rather to phthisical affections. The absence of pain in syphilitic ulcerations of the larynx may indeed lead to the danger of their being overlooked or neglected, though this risk is somewhat compensated by the tendency of these ulcers to heal spontaneously, without any permanent bad results, excepting a certain functional derangement of the voice. The number of

cases is, nevertheless, considerable, in which serious injury to the larynx remained even after a radical cure of the original disease. Of these, the most interesting and important are those instances of membranous cicatrices stretched across the laryngeal tube; since, on the one hand, they involve the gravest disturbance of the laryngeal function, and also, on the other hand, admit of operative interference. The entire number of cases of this kind on record amount to twenty-two—of these, six are described by Elsberg, of New York, while eleven are reported from the south-east of Europe, and the remainder by various writers. It is somewhat remarkable that three-fourths of the European cases occurred in the extreme east, showing the natural indolence and apathy of the inhabitants of those regions, who only seek aid when affected with grave disorder, especially if the attendant pain be inconsiderable.

In narrowing of the larynx by membranous cicatrices, the voice is always impaired, and there also always exists dyspnœa; but the latter is not always in direct proportion to the extent of the membrane and the consequent contraction: for we have in some cases excessive occlusion (stenosis), with but slight dyspnœa, owing to the influence of habit and the slowness of the process; while, in others, dyspnœa may be intense, with only slight narrowing, but supervening rapidly. In SOMMERBRODT's case, the considerable concentric swelling of the laryngeal mucous membrane was a fertile source of dyspnœa, which diminished as the swelling subsided. The true cords are, in most cases, the seat of these membranous cicatrices, by which they are either partially approximated or wholly united, so that they become nearly obliterated. The opening left by the membrane is mostly situated in the posterior portion of the glottis, and is rounded or semilunar. In one case (Havratil) the opening was situated in the middle of the membrane. As to the origin of the membrane, it is always the result of the healing of ulcerated and opposed surfaces coming into more or less continuous contact, be the healing spontaneous, or the result of appropriate treatment. The actual process of the formation, and the time occupied thereby, have only been observed once before, and in the present case. In the former case, described by Rossbach (*Langenbeck's Archiv*, Vol. IX.), there was syphilitic ulceration of the cords near the commissure, and about the right arytenoid cartilage. Under treatment, the ulcers healed; but within eight days the cords became united by a membrane in their anterior two-thirds. In the present case, the anterior third of the cords was united after fourteen days of treatment, and the union became complete after five or six weeks. It will, therefore, always be a matter of practical importance in the treatment of syphilitic cases to institute an energetic and rapid anti-syphilitic treatment on the first appearance of redness and swelling about the anterior commissure of the vocal cords; for, if ulceration has once commenced, more or less extensive union is almost neces-

sarily a consequence of cure. If cicatrization and union have actually taken place, the only alternative of operative treatment remains. The division of the membrane may be effected by means of a fine probe-pointed bistoury. But a simple incision is followed in many cases by only temporary results. The galvanic cautery, or caustic potash, will probably be found more effectual in procuring a permanent destruction of the membrane; but even the most favorable result will scarcely obtain a restoration of the voice; dyspnœa will, on the other hand, be removed. *Berl. Klin. Wochenschr.*, April 1, 1878.

**Gummy tumors of the larynx.** SCHECH, in his valuable contribution to the subject of gummy tumors of the larynx, says that they are the rarest of all the many manifestations of syphilis which affect that organ, and belong to the latest stages of the disease. With the syphiloma, gummy tumor, syphilitic tubercle, or syphilitic infiltration of the larynx, all of which terms are with him indicative of the same lesion, will be found, in the great majority of instances, further specific processes, or at least the sequelæ of earlier lesions, such as cicatrices of the cutaneous surface, of the mucous membranes, diseases of the bones, or, more rarely, of the lymphatic glands; and in cases where the laryngeal appearances are doubtful, he regards these co-indications of the disease as so important, that, were a gummy tumor or its results present in the skin, periosteum, or mucous membranes, he would unhesitatingly pronounce in favor of the gummatous nature of the laryngeal disease.

Though gummy tumors may develop at any point in the larynx, those parts which lie above the level of the glottis appear to be the favorite seat. SCHECH has seen them on the epiglottis, the vocal cords, and on the posterior wall of the larynx. Mandl has observed them on the epiglottis and false cords; and Türck, Nicholas Duranty and Norton, below the glottis-level.

They take their origin in the connective tissue and on those parts contiguous to the blood-vessels, in the mucous membrane and sub-mucous tissues.

Their development is either circumscribed or diffuse, upon which depends their size. In the first instance they will vary from the size of the head of a pin to that of a pea, while in the latter they appear as more or less undefined infiltrations, or irregular and tuberculated masses. The round form, when the appearances are localized, is the predominant one, especially upon the false cords or epiglottis, where they may be arranged in rows like a string of pearls. On the vocal cords they may assume diverse forms. The affected cord will either be changed into a swollen, inflamed, and rounded mass, or will show, upon its free edge or middle, spindle-shaped or rounded protuberances which at first sight resemble very strongly a polypus with a broad base.

Their number will vary as well as their size—we may have a

single example, we may have many. In one of SCHECH's cases he counted nine ; in one case which Mandl reports eleven could be distinguished. To describe the color and the appearance of a laryngeal gummy tumor is a difficult matter, and the reason does not depend so much upon its seat in the superficial or deep tissues, or its diffuse or circumscribed character, as it does upon the stage of its progress in which it is examined ; and just here will probably be found the explanation of the diversity of the descriptions that are given by various authors, of the appearance of the laryngeal gummata. All are correct ; but the reader must remember that each represents the appearance of the tumor at some one particular stage of its development, as it was seen at the time of the examination made by each author. SCHECH states that he knows of no affection of the larynx in which the laryngoscopic picture changes so rapidly and so often, especially when the patient is being energetically treated. One day there may be marked swelling and hyperæmia, a day or two later a purple or bluish-red tumefaction appears—after a short time to disappear and leave behind a normal mucous membrane.

In gummy tumors of the larynx we may distinguish various stages, as well as in like tumors of other parts. The first, usually accompanied by more or less marked inflammatory reaction, is the stage of infiltration ; the second, softening ; third, resorption ; and, fourth, degeneration. To fix accurate limits for these stages, as regards time, is impossible ; the stage of degeneration or sloughing of the tumor is usually the shortest, and that of infiltration the longest. The gummatous infiltration can persist without showing the slightest change for months, while on the other hand it may, as it often does, quickly soften and pass into the stage of sloughing.

(In the original paper a careful description of these stages and their laryngoscopic appearances are given.)

The symptoms caused by laryngeal gummata vary according to the seat of the affection and the events to which it gives rise. Ordinarily, disturbance of vocalization is met with, and the more or less marked hoarseness or aphonia may depend on various causes, as, for instance, nodular infiltrations in the vocal cords, or between the arytenoid cartilages ; likewise upon œdema of the neighboring tissues, swelling of the ary-epiglottic folds, and paralysis of the adductor or abductor muscles of the vocal cords. If sloughing of the gummatous tumor follow, the ulcerations or their resulting cicatrices, as well as perichondritis and its sequelæ, lead not unfrequently to an incurable aphonia.

Dysphagia and laryngeal irritation are usual complaints. Much less frequently, and only in cases where the infiltration is extensive, or attended by great œdematous swelling, is the respiration affected. Dyspnœa may, as well as the hoarseness and dysphagia, rapidly disappear with the absorption of the gummy tumor ; or, on the contrary, they may remain for life, especially when wide-

spread sloughing leaves contracting cicatrices of the glottis, distortion of the laryngeal parts, and prolapse of the laryngeal walls, from loss of portions of the cartilages.

From what has been said, it can be seen that the prognosis, in gummy tumors of the larynx, is at best a doubtful one.

Their diagnosis is one of the most difficult in the whole range of the laryngeal pathology. The reason lies in the rapidly-changing appearances of the laryngeal picture, already alluded to. In the stage of infiltration a certain diagnosis is often impossible. The differential diagnosis from the following affections deserves special attention :

Localized hypertrophy of the tissues in the posterior commissure of the larynx ; of the vocal cords or false cords, met with in chronic laryngitis.

From the papillary outgrowths, resembling somewhat a gummy tumor, which occur in syphilitic persons as a result of chronic catarrh.

From the laryngeal condylomata, especially from laryngeal abscess ; from the so-called laryngeal follicular bubo—an hypertrophied, degenerated, and suppurating follicle ; finally, the appearance sometimes seen on the free edge of the epiglottis, and which is caused by the cartilage showing through the mucous membrane, has been confounded with a small, recently-softened, and dirty-white-colored gummy tumor in the same locality.

In urgent cases, potash in large doses is indicated in treatment ; in less severe cases, and in those which have received no medication, inunction or inhalation may be recommended. In many cases the potash salt in small doses is sufficient to cause the most brilliant results in a short time—results which SCHECH cannot ascribe alone to the local treatment of the larynx. Still, the latter must not be omitted, and will, for inflammatory conditions, consist in inhalations and the insufflation or fluid application of astringents, which ought to be frequently changed. General infiltrations and hard nodulations are best treated by penciling them with diluted tincture of iodine.

The treatment of ulcers, œdema, abscesses, perichondritis, pareses, and cicatrices, is to be conducted on general principles.

A very good chromo-lithographic plate appears with the article illustrating the following appearances : 1. A softened and superficially ulcerated gummy tumor of the posterior laryngeal wall ; 2, 3, 4. A gummy tumor of the right vocal cord, in the stages of infiltration, softening, and slough ; 5. Numerous softened gum-mata of the epiglottis, and recent one of the left vocal cord ; 6. The same in the stage of absorption. *Deut. Archiv. für Klin. Med., Band XX., Heft. I. und II., Aug. 17, 1877.*

**Syphilis of the trachea.** DR. VIERLING has collected from various sources the records of forty-six cases of syphilis of the trachea and bronchia (including one of his own, the details of

which he gives in full, with the autopsy), and arranged them in tabular form. The paper will therefore be found a very convenient one for reference by those who may be interested in the subject. From an analysis of the cases we learn that the earlier and milder lesions of syphilis, condylomata, etc., hardly ever affect the trachea, and that ulcerative processes and their sequelæ, cicatrices, are alone commonly found, though a simple catarrh may have existed for a long time previously, without recognition. In the majority of cases contraction of these cicatrices leads to narrowing of the lumen of the trachea, but extension of the ulceration to the deeper tissues may perforate the tracheal wall and give rise to an external abscess (Wallmann.) Perforation into a neighboring blood-vessel has twice occurred when the ulcer was situated in the left bronchus (Gerhardt, Kelly.) In both instances the left pulmonary artery was opened. The table further demonstrates that the syphilitic affection extends either throughout larynx, trachea, and bronchia, or limits itself to the trachea and bronchia, leaving the larynx uninvolved, the first form being the one most frequently met with. Thirty out of the forty-six cases collected, more than one-half, had laryngeal syphilis. If the latter is present, the tracheal mucous membrane will probably be involved throughout, certainly in its upper parts. It may, however, but very rarely, be unaffected at this point. In syphilis of the tracheal mucous membrane alone, the chief locality will be found just above the bifurcation. At this point, likewise, will stenosis usually occur.

Reference to the table gives us, regarding the seat of the syphilitic disease, the following facts : In thirty cases out of forty-six the larynx was diseased ; thirty-six in which the tracheal mucous membrane, with or without implication of that of the bronchia, showed evidences of syphilis ; and finally, in five was the bronchial mucous membrane alone affected.

If the disease appear in the bronchia, its seat will probably be in those of the largest size, either right or left ; more rarely will it be found lower in the tubes, and never in those beyond the third and fourth order.

The sex of thirty-nine cases was as follows : twenty-three males and sixteen females. The ages, in the first *decennium*, two ; in the second, two ; in the third, eleven ; in the fourth, twelve ; in the fifth, eight ; and in the sixth, four cases. Those of the ages of from one to twelve years being attributable to congenital syphilis.

The duration of tracheal and bronchial syphilis is difficult to determine, because patients cannot give a clear history as regards the commencement of their symptoms. Cough, purulent expectoration, slight dyspnœa, often intermittent, and if the larynx be involved, hoarseness or aphonia. (The majority of the cases were seen and treated in hospital.)

The prognosis is in the majority of instances unfavorable, and



the writer recommends that all cases of persistent tracheal and bronchial catarrh in syphilitic subjects should be carefully watched, and that it is often better to try an anti-syphilitic course of treatment at once rather than wait until the severe symptoms of the disease appear. In the latter case no one will deny the necessity of active therapeutics.

If stenosis have occurred, it is all important for the prognosis whether the constricted point be located in the upper or lower parts of the trachea. If above, tracheotomy will be successful, and the stricture may be included in the necessary incision and dilated at once (Semeleder's successful case.) Trendelenburg completes the work of dilating the divided stricture, by first passing bougies through it from the tracheal wound, then from the mouth, and later substituting zinc plugs, which dilate by their weight(?).

Schrötter has further developed Trendelenburg's method, and, as is well known, has successfully employed it in several instances. *Laryngologische Mittheilungen, Wien, 1875.*

Schnitzler's method (*Wiener Klinik, 1877*), of cutting through the stricture by means of a specially constructed knife, used through the mouth, and then keeping it dilated by means of hollow bougies, can only be employed in those cases where the constriction is high up in the trachea, and cannot be used when dyspnœa is excessive, unless a tracheotomy has been performed.

In cases where the stricture is low down, tracheotomy is of course useless, and herein lies the reason, probably, why so many cases have died shortly after its performance. In the table of cases referred to, we find fourteen tracheotomies: in two cases with permanent relief, or cure; in two with an improvement lasting several months; in the remainder death followed in either a few hours or days. *Deut. Archiv. für Klin. Med., April 16, 1878.*

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MAURIAC. On naso-pharyngeal syphilis. 8vo. Delahaye, Paris, 1878.

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PORTER, W. S. Syphilis of the air passages. *Chicago Med. Jour. and Exam., p. 50, January 1878.* (St. Louis Clin. Record, p. 245, Jan. 1878.)

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- SIMON. On gummy tumors of the tongue. *Thèse de Paris*, No. 125, 1877.  
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 WALKER. Iodide of potassium in gummy tumors of the soft palate. *Detroit Lancet*, p. 133, Feb., 1878.  
 ZANNINI. On syphilitic affections of the tongue. *Rivista Clinica*. p. 238, August, 1875.

## SYPHILITIC DISEASES OF THE EYE.

RICHARD H. DERBY, M. D.

**Syphilitic iritis.** DR. T. R. POOLEY gives a resumé of the symptoms and treatment of syphilitic iritis and a partial analysis of fifty cases of this affection. In reference to the syphilitic infection in which iritis occurs, the author thinks that it belongs as a rule to the earlier stages of secondary syphilis. In reference to this point, he found that in fifteen cases there were secondary manifestations present, at the time of the outbreak of the iritis. [The author's views in regard to treatment seem to us, in general, wise and well expressed. The only exception is, perhaps, the importance he attaches to local blood-letting in all cases of acute iritis. While we recognize the value of leeches as a remedial agent in iritis, we would rather restrict their use to those cases where there was evidence of cyclitis, where the eye was painful upon pressure.—*Rep.*] *The Ohio Medical and Surgical Journal*. October, 1876, p. 201.

**Progressive choroditis in acquired syphilis.** JONATHAN HUTCHINSON. In a clinical lecture on progressive choroiditis in connection with acquired syphilis, the author describes three interesting cases. In one of them, within a few years of a mild attack of syphilis, there was a choroiditis, affecting both eyes, and in the course of a year the patient was nearly blind. After this, possibly under specific treatment, one eye improves and the patient is enabled to read. Then for twenty years things remain unchanged. Then in connection with sexual loss of tone, there is increased difficulty in sight. Together with the choroiditis, the development of posterior cataract was noticed. *Medical Times & Gazette*, November 17, 1878, p. 535.

**Syphilitic diseases of the eye-lid.** REISSL gives a series of articles in the *Allgemeine Wiener Med. Zeitung*, on syphilitic diseases of the eye-lid. The author recognizes three forms of syphilitic diseases of the eye-lid; primary induration, erythematous and papulose eruptions, (syphilitic exanthemata,) and gumma. Papulose diseases are distinguished from gumma by the subsequent ulceration being superficial, whilst the ulceration following gum-

mata in the eye-lids, is deep and destructive. The great peculiarity of syphilides in this region is their great malignity and the destruction of tissue which they cause. *The London Medical Record*, December 14, 1877, p. 504.

**Syphilis of the eye-lids.** C. S. BULL writes an exhaustive treatise on the literature of syphilis of the eye-lids, and reports four cases representing syphilitic infiltration and ulceration of the eye-lids, involving both the cutaneous and mucous surfaces, which were originally localized deposits, as in the tubercular syphilides. *New York Medical Journal*, March 1878, p. 522.

**Syphilitic oculo-motor paralysis and amaurosis.** LEARED. The author describes an oculo-motor paralysis and atrophy of the optic disc, probably due to syphilitic growth. In this case there appears to have been as well, a paralysis of the superior oblique and external rectus. Under the use of the biniodide of mercury, and the iodide of potash, the function of the ocular muscles returned, but with this no relief to the amaurosis. *Medical Times and Gazette*, April 13, 1878, p. 390.

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 WATSON, W. SPENCER. A case of obstruction to the lachrymal passage, with ozoena due to syphilitic rhinitis. *Med. Times and Gaz.*, p. 58., Jan. 19, 1878.

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## SYPHILIS OF THE NERVOUS SYSTEM.

BY E. C. SEGUIN, M. D.

### **Syphiloma of the pons varolii with remarks on unilateral cerebral anesthesia and disturbance of the senses.**

ROSENTHAL reports a remarkable case, made complete by an autopsy. There was crossed paralysis during life, viz: affection of the left trigeminus (including lingual branch), third and sixth nerves, with paresis of the right side of the body. Later, paralysis also appeared on the left side. ROSENTHAL diagnosed a lesion in the pons varolii, and in spite of the patient's statements thought it to be syphilitic. Autopsy showed several small syphilomata in the pons. Nothing is said of the state of the optic nerves. *Apropos* of this case presenting loss of the sense of taste on the left anterior part of the tongue, ROSENTHAL makes some interesting remarks upon the use of the galvanic test for taste. He considers it the most reliable, and applies it directly to the

mucous membrane or through the throat. As the result of numerous examinations he is led to believe, that in peripheral affections of the gustatory nerve the galvanic reaction is not lost, while in organic disease of the nerves or centres it is abolished or much reduced. Imp. Roy. Med. Soc., Vienna. *Lond. Med. Record*, Jan. 15, 1878.

**Paralysis of the insane and cerebral syphilis.** Three cases of LEIDESDORF are related by the author, but he does not point out the characters by which true general paralysis can be distinguished from the syphilitic pseudo general paralysis, as shown by Mickle and Fournier. In one of LEIDESDORF's cases recovery took place and had lasted ten years at time of reporting. Imp. Roy. Med. Soc., Vienna. *Lond. Med. Record*, p. 41, Jan. 15, 1878.

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## Reviews and Book Notices.

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*On the Treatment of Chronic Eczema by a Glycerole of the Sub-acetate of Lead.* By Balmanno Squire, M.B., London. J. & A. Churchill. Second Edition, 1878, pp. 43.

*On the Treatment of Psoriasis by an Ointment of Chrysophanic Acid.* By Balmanno Squire, M.B., London. J. & A. Churchill, London, 1878, pp. 99.

*Port-wine Mark and its Obliteration without a Scar.* By Balmanno Squire, M.B., London. J. & A. Churchill. Second Edition, 1877.

*Atlas of the Diseases of the Skin.* By Balmanno Squire, M.B., London. J. & A. Churchill, 1878. Part I. Four plates, pp. 89.

In the first of these brochures, Mr. Squire brings forward a local remedy for chronic eczema which is of undoubted value, although in our opinion, the estimate he places upon it is too high. He proposes to make a preparation of the acetate of lead with glycerine instead of water, giving the following formula: Take of acetate of lead 5 parts, litharge  $3\frac{1}{2}$  parts, glycerine 20 parts. Heat for half an hour in a boiling glycerine bath, constantly stirring, and filter in a hot compartment. This is the "stock," which is generally to be used diluted, a drachm or even half-a-drachm to the ounce of pure glycerine, or stronger, according to the effect produced. The writer has found it advantageous to use water with the glycerine, as it is known that glycerine has such an intense affinity for water that when pure it will even dry tissues; and many skins cannot bear it. If then it is serviceable to add water to the mixture, we cannot see what advantage the glycerole of lead has over the "liquor plumbi sub-acetatis" made with water, and would suggest that trial of the strong preparation of the pharmacopœia be made, in glycerine, say 3 ss. or 3 j. ad 3 j. or stronger, with water, if the part requires it.

There are one or two statements in this essay which should be criticised: Mr. Squire speaks very disparagingly of diachylon ointment, as a "putty-like substance," difficult to handle and apply. Surely he has never had it prepared properly; if made exactly after the formula of Hebra, and kept under water, it will be found perfectly manageable, and if he will have it spread on muslin or lint, as it should be, instead of rubbed on the skin, he will have no difficulty in applying it to any surface. Again, he says, speaking of diachylon and oxide of zinc ointments, "that no variation of their strength seems to have been contemplated by those who have advocated them; nor does such an idea appear

to have presented itself to any of the numerous adopters of these two preparations." This is by no means true, for in practice intelligent physicians here are continually found to vary their strength.

The second monograph of ninety-nine pages is entirely devoted to the discussion of the single remedy chrysophanic acid in psoriasis : of the advantage and disadvantage of this method our readers are fully aware through the Digest Department. Forty pages of finely printed matter are given to extracts from journals, letters, etc., which form a valuable compend of what is known in regard to this really effective agent.

Mr. Squire's plan of obliterating flat vascular nævi, or port-wine mark, without a scar, by means of multiple scarifications has been already described in this issue, page 223 : the details are very carefully given in this brochure on the subject, which it will be well for any one to possess who undertakes the removal of one of these deformities, of any size.

We wish that we could give unqualified praise to this "Atlas of the Diseases of the Skin" as the author calls it, but feel that in the interests of Dermatology, criticism is of more value. The part before us consists of an octavo book of eighty-nine pages of letter-press and four colored plates, referring to the two subjects of nævus vascularis planus, and psoriasis ; the plates are about two-thirds life size, the sides of course being much curtailed to put them in the small compass of an octavo.

The first two plates represent nævus, and are the same as appear in the last-mentioned brochure. The third plate is labelled psoriasis diffusa ; "Plate IV. represents no pathological condition whatever," but as the author further says, it shows the patient exhibited in Plate III. as cured. What the advantage of introducing the portrait of a perfectly smooth and healthy skin is, we cannot conceive, and should judge that purchasers would be annoyed at paying for a normal instead of pathological picture. If Mr. Squire had shown us the picture of one of his worst cases of nævi, cured without a scar, it would have been more satisfactory.

(9) The first portion of the text is very much a reprint of the last-mentioned brochure ; the second part on psoriasis dwells largely on the author's method of treating psoriasis with rubber clothing. We wish Mr. Squire would not speak so lightly of "curing" psoriasis in so many days or weeks, when he only means the removal of the eruption which was then out ; such language does discredit to dermatology.

We shall look with interest for subsequent parts, in regard to which, however, the author makes no promises as to their number or time of appearance. The letter-press of the present part is good, but there is considerable room for improvement in the artistic elements of the plates, judging from the beautiful work which has been done in London, on Hutchinson's *Atlas of Clinical Surgery*, and the Sydenhams Society's *Atlas of Skin Diseases*.

*Sycosis, Prize essay for 1877, of the Bellevue Hospital Medical College Alumni Association.* By A. R. Robinson, M.B., L. R. C. P. & S. Edin. New York, D. Appleton & Co., 1877, pp. 48.

The Bellevue Alumni Association does credit to itself in giving its prize for such an essay as the one before us, which is reprinted from the *New York Medical Journal*, for August and September, 1877, and the study and practice of medicine will be advanced in proportion as such original investigations shall be made upon the more common diseases.

We take great pleasure in directing special attention to the laborious work of our esteemed co-laborator, because the present instance is such a confirmation of the real value of pathological research in its application to practical medicine. In this study of true sycosis, Dr. Robinson has taken the bold stand that the disease is not a folliculitis at all, but a *peri-folliculitis*, and proves it by his microscopic sections, the original of which we have ourselves studied with Dr. R., and can vouch for the truthfulness of his work.

He believes that the direct exciting cause of the eruption is found in the "irritation produced by the stiff hairs of the beard in the irritable skin tissue." The rich supply of blood-vessels and nerves around them, predisposes them to such an irritable condition, which is excited by such irritants, as shaving, dust, the sun, etc. General debility he considers a predisposing element of importance, and eczema is also frequently an element of causation.

The *peri-follicular* nature of the eruption is shown by the changes seen microscopically, where pus is distinctly seen to be formed entirely outside of the follicle, and is not seen within until it has penetrated the root sheaths from without.

The study of Sycosis must undoubtedly be accepted as representing its true nature, and is indeed a valuable contribution to dermatology. The drawings of the microscopic sections, which are Dr. Robinson's own work, are excellent.

Dr. Robinson recognizes, of course, what is commonly called parasitic sycosis, and gives the differential diagnosis between this and true sycosis; he very properly urges that the eruptions due to the parasite be no longer called a sycosis, for it is never a *peri-folliculitis*, but that it should be classed under its head as *tinea barbæ*.

*Clinical Lectures on the Tineæ, at the Hospital St. Louis, Paris.* (Leçons Clinique sur les Teignes, etc.,) par Dr. C. Lailler, Paris. Delahaye, 1878, pp. 112 and 4 plates.

The French School of Dermatology has as yet given us no one who stands out in prominence, since Bazin has been placed on the retired list and Hardy has voluntarily devoted his thought and energies to general medicine. Notwithstanding the enormous clinical advantages of the Hospital St. Louis and its former prestige, the French School of Dermatology has undoubtedly but

a small share of the influence which it once possessed ; it remains for the present incumbents to make it to be again of power. We welcome the recent work of Dr. Lailler, also that of Fournier and Guibout, as indicating that they still endeavor to maintain the activity of this center of instruction.

This volume is a fair presentation of the subject of the vegetable parasitic diseases, but the author still holds to the parasitic nature of alopecia areata, contrary to the almost universal opinion of recent observers.

The plates of the microscopic appearances of the parasites are new and good ; the two colored photographs, one of tinea tonsurans and one of alopecia areata, are excellent.

*Decennial Report of the Clinic for Skin Diseases and Syphilis at the University of Palermo.* (Un decennio di Clinica dermo-sifilopatica dell'Università di Palermo.) Rio del Prof. Giuseppe Profeta, Palermo, 1878.

This decennial report of the Palermo Clinic for skin and venereal diseases, constitutes a volume of 166 pages with 22 photographic plates appended. After an introductory chapter containing statistical tables of the 1502 cases treated during the decade, there follows a series of brief and interesting papers, a few of which have already appeared in print. The photographs form an important feature of the volume, and represent cases of syphiloderma, psoriasis, elephantiasis, lupus, pellagra, favus, lepra, nævus, cheloid, fibroma, and ichthyosis. These photographs although uncolored, are remarkably fine representations of the above diseases, and show clearly the great value of photography in the portrayal of cutaneous affections.

G. H. F.

*Catalogue of the Models of Diseases of the Skin in the Museum of Guy's Hospital.* By C. Hilton Fagge, M.D., Curator of the Museum ; Assistant Physician to and Lecturer on Pathology at the Hospital ; formerly Demonstrator of Cutaneous Diseases. London, J. & A. Churchill, 1876.

The author has succeeded admirably in accomplishing the very difficult task of re-classifying the skin models contained in Guy's Hospital Museum. He commences by first giving a nomenclature of skin diseases based on the clinical nature of the affections, and, while there are many objections to it, it is in our opinion better, in the present state of our knowledge of the pathological states existing, than a classification having an anatomico-pathological foundation.

The number of models classified is 537, and comprehends nearly every variety of skin disease known. Where found practicable, a description of the model is given, with a history of the case.



We object to the use of such terms, as syphilitic lichen, and syphilitic impetigo, believing that the same object would be attained by designating them by the names of papular syphiloderma and ulcerating syphiloderma respectively. We do not agree with the author, when he says that the pruritus hiemalis, as described by Duhring, and the prurigo of Hebra are one and the same disease. The first case which he cites, as one of prurigo, may have been a chronic lichen; but, from the indefinite history given, it would be difficult to form a correct diagnosis. The second case is evidently one of pruritus senilis.

The work gives us a very good idea of the opinions held by one of the leading dermatologists of the English, in contra-distinction to the Vienna School of Dermatology.

In conclusion, the author has done great service for those who wish to make a study of the models contained in the Museum.

R. C.

*Relation of Syphilis to the Public Health.* By Frederick R. Sturges, M. D., New York, 1877, pp. 40.

*The Lymphatic Theory of Syphilitic Infection, with a New View of the Relation between the Chancre and Chancroid, and Suggestions for the Treatment of Syphilis.* By William A. Hardaway, M. D., New York. D. Appleton & Co., 1878, pp. 26.

*Early Syphilis in the Negro.* By I. Edmond Atkinson, M. D., Baltimore, 1877, pp. 12.

I. In this brochure, the author gives us an account of the influence of syphilis on the public health, relying upon carefully drawn statistics gathered from various sources, to uphold him in his statements. He treats the subject under the following heads: 1. Is syphilis of common occurrence? 2. Can it be considered a disease fatal to life? 3. Does it favor the development, or fatally influence the course of other diseases? To the first of the questions, he answers: "Syphilis is probably widely spread and possibly increasing in extent. This opinion, from the imperfect means at our disposal, must for the present at least remain more or less conjectural." To the second, the reply is, "No." In conclusion, he is of the opinion that "acquired syphilis is comparatively harmless and congenital syphilis fatal in their influence over the course and development of other diseases."

There is also an elaborate appendix containing the statistics from which the conclusions contained in the work are drawn.

II. Dr. Hardaway, in a paper which he read at the meeting of the *American Dermatological Association*, gives a full account of the literature in support of the theory of the absorption of the syphilitic virus by means of the lymphatic system, and narrates cases to uphold this view. He also enters into the subject of the relation existing between chancre and chancroid. He believes

that the syphilitic virus obtains an entrance into the system through the lymphatics, and therefore recommends, for the radical cure of syphilis, a very early excision of the enlarged and indurated glands in the groin, before the poison has passed there and affected the nest set of glands.

III. The author bases his report on an analysis of one hundred cases observed by him in dispensary practice. Secondary symptoms were observed in eighty-two cases; in forty-nine of these, infection had taken place six months or less, previous to being seen; in sixteen, more than six months, and less than a year had elapsed from the appearance of the primary sore, until secondary symptoms manifested themselves; in six cases more than a year had passed by; in the remainder nothing definite could be ascertained. In the majority of cases adenopathy other than inguinal occurred during the secondary period of the disease. He then proceeds to give the relative frequency of the different forms of eruption encountered, such as papular, pustular, etc. The class of patient met with, presented a scrofulous diathesis. The treatment adopted was mercurial, in combination with tonics.

R. C.

*Dermatology in America, Being the President's Address before the First Meeting of the Dermatological Association, at Niagara Falls, New York, September 4, 1877.* By James C. White, M. D., 1878, pp. 14.

This address has already appeared in the columns of this Journal. It contains a brief account of the rise and progress of dermatology in this country. Appended to the article is a list of American writers on dermatology, together with the titles of the various subjects on which they have written. It is valuable as a means of reference, to those who are interested in dermatology.

R. C.

*A Clinical Study of Molluscum Contagiosum.* By George Henry Fox, M. D., Chicago, 1878, pp. 10.

In this paper, which is based on the records of twenty-five cases, the author notes the frequent occurrence of warts in connection with molluscum contagiosum. In concluding, he says, that it is a point worthy of investigation, whether molluscum and verruca bear any relation to each other.

R. C.

*On the Various Forms of Pruritus Cutaneus and their Treatment* By R. W. Taylor, M. D., New York, 1877, pp. 18.

This monograph deals with the question of pruritus in its various forms. While not making any claims to originality the author has presented the subject in a very readable form and given some valuable hints as to the treatment of this most distressing affection.

R. C.

*Faulty Innervation as a Factor in Skin Diseases.* By Edward Wigglesworth, M. D., New York, 1878, pp. 7.

We have, in this article, an account of the observations made by the author and others, on four cases of nerve lesion, followed by increased action of the sudoriparous glands, in one of which there was in addition, a morbid production of hair. The paper is of value and interest, as it assists us in the establishment of the intimate relation existing between the nervous system and cutaneous affections.

R. C.

*Surgical Uses other than Hæmostatic of the Strong Elastic Bandage.* By Henry A. Martin, M. D., Boston, 1877, pp. 27.

The author proposes a new method of treating ulcers of the leg, viz : by means of a "pure rubber" bandage. He says that he has constant and unvarying success by adopting this method of treatment, and has employed it for over twenty years. He has found that ulcers, associated with a varicose condition of veins, yield most readily to this treatment. It has also been used by him in the treatment of erysipelas and erythema of the leg.

R. C.

*A Case of Unilateral Idiopathic Cutaneous Atrophy.* By I. E. Atkinson, M. D., Louisville, 1877, pp. 8.

This paper contains the history of a very rare form of disease ; unilateral idiopathic atrophy of the skin. The disease occupied portions of the left side of the body, over the thorax and abdomen, and also the left thigh. The patches presented a mottled aspect, the hairs over these areas were diminished in number, and the affected surface presented large and tortuous veins. The skin of the diseased portion was thinner than elsewhere : there had been no infiltration, no induration of the affected part, and the lesion had lasted as long as the patient could remember.

R. C.

## Books and Pamphlets Received.

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*Clinical Treatise on the Diagnosis, Treatment and Prognosis of Venereal Symptoms.* (Klinisk Veiledning til Diagnose, Behandling og Forebyggelse af veneriske Sygdomme,) af Dr. S. Englested. Copenhagen. C. A. Reitzels, 1878, pp. 489.

*The Idiopathic Diseases of the Mucous Membrane of the Buccal Cavity.* (Die Idiopathischen Schleimhautplaques der Mundhöhle [Leukoplakia Buccalis,]) von Dr. Ernst Schwimmer. Vienna. W. Braumüller, 1878, pp. 122 and 5 plates.

*A New Method of Treatment of Syphilis and Mercurial Disease, with Special Reference to Sulphur Waters and Baths.* (Neue Erfahrungen über die Behandlung der Syphilis und Quecksilber-Krankheit mit besonderer Berücksichtigung der Schwefelwässer und Soolbäder,) von Dr. J. Edmund Guntz. Dresden. E. Pierson, 1878, pp. 149.

*Nurses and Syphilitic Nurslings.* (Nourrices et Nourrissons Syphilitiques,) par Dr. Alfred Fournier. Paris. V. A. Delahaye et Cie., 1878, pp. 95.

*On the Use and Indications for the Employment of Baths in Diseases of the Skin.* (Du Rôle et des Indications des Bains dans les Maladies de la Peau,) par C. A. Carry. Paris. Delahaye, 1877, pp. 110.

*Vulvar Elephantiasis Among Europeans.* (De L'Eléphantiasis Vulvaire chez les Européennes,) par Henri Cellard. Paris. J. B. Baillière & Fils, 1877, pp. 67.

*A Microscopic Study on the Growth and Change in the Hair.* (Mikroskopische Studien über Wachstum und Wechsel der Haare,) von Prof. V. v. Ebner, Vienna, 1876, pp. 56 and 2 plates.

*On the So-called Pigmentary Syphilide.* By Geo. Henry Fox, M. D. (Extracted from the *American Journal of the Medical Sciences*, for April, 1878.) pp. 6.

*The Vienna Clinic for Syphilis.* (Die Wiener Klinik für Syphilis,) von Dr. C. Sigmund Ritter v. Ilanor, Vienna. W. Braumüller, 1878, pp. 53.

*The Relations Existing Between Eczema and Psoriasis.* By Robt. Campbell, M. D., New York, 1877, pp. 9.

*Auto-Inoculation of Vegetable Parasites of the Skin and the Clinical Testimony for their Identity or Non-Identity.* By Edward Wigglesworth, M. D., New York, 1878, pp. 9.

*On Certain Points Relating to the Nature and Treatment of Lupus.* By Henry G. Piffard, M. D., Albany, 1877, pp. 10.

*General Pseudo-Paralysis of Syphilitic Origin.* (De la Pseudo-Paralysie Générale D'Origine Syphilitique,) par Dr. A. Fournier, Paris. V. A. Delahaye et Cie., 1878, pp. 24.

*Lupus, Syphilis, and Cancer, with a Notice of a Rare Form of Lupus. Lupus Cornutus.* (Lupus, Syphilis und Flächen Krebs, etc.,) von Dr. E. Lang, Vienna, 1878, pp. 8.

*A Case of Epithelioma Combined with Lupus.* (Ueber einem Epitheliomartigen Fall von Lupus, [Syphiliticus?]) von Dr. Hermann Martin, Vienna, 1877, pp. 17.

*On Chemical Exanthems, Especially the Quinine Exanthem.* (Ueber Arznei-Exanthems, insbesondere über Chinin-Exanthem,) von Dr. Heinrich Köbner, Vienna, 1877, pp. 27.

*A New Contribution to the Study of Zoster. Zoster Recidivus.* (Neuer Beitrag zur Lehre vom Zoster, etc.,) von Kaposi, Vienna, 1877, pp. 12.

*Clinical Lectures on the General Pathology of Skin Diseases.* (Klinisches Vorlesungen über Allgemeine Pathologie der Hautkrankheiten,) von Prof. J. Neumann, Vienna, 1878, pp. 13.

*On Nerve Nævus.* (Ueber Nævus papillaris. Nerven Nævus,) von Prof. J. Neumann, Vienna, 1877, pp. 8.

*On the Use of Boracic Acid in Skin Diseases.* (Ueber die Anwendung der Borsäure gegen Hautkrankheiten,) von Prof. J. Neumann, Vienna, 1877, pp. 4.

*On the Treatment of Psoriasis Vulgaris, Tinea Tonsurans and Pityriasis Versicolor, with Chrysophanic Acid and Goa Powder.* (Ueber die Psoriasis Vulgaris, etc.,) von Prof. J. Neumann, Vienna, 1878, pp. 11.

*A Case of Intermittent Febrile Urticaria.* (Ein Fall von Febris Intermittens Urticata,) von Prof. H. Zeissl, Vienna, 1877, pp. 4.

*On the Difficulty Encountered in the Diagnosis of Venereal Affections.* (Ueber die Schwierigkeiten, welche sich der Diagnostik Leutischer Affectionen entgegenstellen,) von Prof. Dr. H. Zeissl, Vienna, 1878, pp. 13.

*On Lupus Syphiliticus and Scrofulosus.* (Ueber Lupus syphiliticus und scrofulosus,) von Prof. Dr. Auspitz, Vienna, 1878, pp. 12.

*The Virus of Venereal Sores, its Unity or Duality.* By Freeman J. Bumstead, Philadelphia, 1877, pp. 10.

*Variations in Type and in Prevalence of Diseases of the Skin, in Different Countries of Equal Civilization.* By James C. White, M. D., Philadelphia, 1877, pp. 20.

*Annual Report of the Pennsylvania Free Dispensary for Skin Diseases.* Philadelphia, 1877, pp. 12.

*Seventh Annual Report of the Dispensary for Skin Diseases.* Philadelphia, 1878, pp. 14.

*Syphilitic Phthisis.* By Wm. Porter, M. D., St. Louis, 1877, pp. 7.

*Syphilitic Sciatica.* By N. B. Emerson, M.D., New York, 1877, pp. 16.

*Syphilis Causing Disease of the Eyelids.* (Die durch Syphilis hervorgerufenen Erkrankungen der Augenlides,) von Prof. Dr. H. Zeissl, Vienna, 1877, pp. 14.

*Baths and their Uses in the Treatment of Diseases of the Skin.* By John W. Shoemaker, M. D., Philadelphia, 1878, pp. 31.

*The Pathology of Herpes Zoster Clinically Considered.* By George H. Rohé, M. D., New York, 1878, pp. 3.

*Multiply scarifier* (Mr. Balmanno Squire's) *for the Treatment of Port Wine Marks, etc.* J. Weiss & Son, London, 1878, pp. 4.

*Some Remarks on a Recent Contribution to the Literature of Regulated and Supervised Immorality.* By the Rev. C. S. Collingwood. Sunderland, 1874, pp. 22.

*The Influence of Legislation on Public Morals.* London, 1874, pp. 16.

*Compulsory Medication of Prostitutes by the State.* (Republished from the Westminster Review, July 1876, by the New York Committee for the Prevention of Licensed Prostitution,) pp. 23.

*An Address on Recent Proposals to Introduce the System of Regulating or Licensing Prostitution into the United States, etc.* Edited by J. Birbeck Nevins, M. D., London, 1878, pp. 98.

*The Contagious Diseases Acts a Sanitary Failure—Opposed to the Amelioration of Society and to National Morality and Incompatible with Christianity.* *An Address.* By C. H. Routh, M. D., London, 1877, pp. 19.

## Miscellany.

## THE METRIC SYSTEM IN A NUT-SHELL.\*

"Universality, Uniformity, Precision, Significance, Brevity and Completeness. A system of weights and measures born of philosophy rather than of chance."—*Charles Sumner*.

BY EDWARD WIGGLESWORTH, M. D.

"WASHINGTON, May 3.—Surgeon-General Woodworth, of the U. S. Marine Hospital Service, has issued a circular, with the approval of Secretary Sherman, requiring medical officers of the Marine Hospital Service to make use hereafter for all official, medical and pharmaceutical purposes, of the Metric System of Weights and Measures, which had already, under the act of July 28, 1866, been adopted by this service for the purveying of medical supplies."—*Boston Daily Advertiser*.

The Metric System is already *legalized* in both America and England. The only question now is, which of the two, the most progressive or the most conservative nation on earth, shall be the first to definitely and finally adopt it as an *exclusive* system? [N. B.—England was 400 years behind the continent in adopting our present arithmetic.] Russia has already taken the preliminary steps towards its final adoption. The rest of the civilized world long since made the system obligatory, in whole or in part, except that, in Sweden alone, its obligatory use is to date from a period in the future, 1879.

Now, what is this Metric System? Metric is from the Greek word "metron," a measure, spelled with Epsilon, e short, and, therefore, pronounced met-ric.

The Meter [measure] is, practically, a fixed quantity, namely, the ten millioneth part of the earth's quadrant from the Equator to the North Pole. With the Meter everything can be *measured*, for it is itself the unit of length; a cube, the edge of which is the tenth of a meter, is the unit of capacity [Liter], and the weight of a cube of rain water, at its extreme contraction, the edge of which cube is a hundredth of a Meter, is the unit of weight [Gram].

It is the Gram alone which concerns physicians, for, in the Metric System, *everything is best prescribed and dispensed by weight*

\*We gladly give space to the following brief exposition of the Metric System, by our esteemed Collaborator, Dr. Wigglesworth. It is reprinted from the *Boston Medical and Surgical Journal*, June 13, 1878, in the form of a circular, which we here insert for the benefit of our readers. The "Archives" will make use of this system as rapidly as the interest and convenience of its readers seems to warrant.—*Ed.*

*alone* ; numbers upon a prescription paper being regarded by the pharmacist as representing Grams, unless the contrary is expressly stated. The fractions are always decimal.

The table is easily learned. It consists of six words, as prefixes, whether we deal with Grams, Liters, or Meters. These are: Deci for tenth, Centi for hundredth, Milli for thousandth ; Dekka for ten, Hekto for hundred, Kilo for thousand. Having these few words, the terms of Troy, Avoirdupois and Apothecaries' weight, and of liquid measure, may be relegated to the limbo of pounds sterling, shillings, four-pence ha'pennies and farthings. As we say dime, cent, mill, so we say decigram, centigram, milligram. These prefixes are Latin, and *diminish* the value. Dekka, hekto and kilo are Greek, and *increase* the value. The mnemonic is G I L D, *i. e.*, Greek Increases, Latin Decreases. Dekka occurs in the English word decade ; hekto in hecatomb ; kilo in chiliad.

"Being accustomed to the words mill, cent, and dime, we shall find the words 'milligram,' 'centigram,' and 'decigram' quite as simple and easy to pronounce as our words 'pennyweight-troy,' 'hundredweight-avoirdupois,' 'scruple-apothecaries,' etc., notwithstanding the assertion to the contrary of those who grieve to give up the 'short and sharp Anglo-Saxon words used in our present *familiar* old tables of weights and measures."

Practically, moreover, for physicians, the whole system is reduced to grams and centigrams, just as, in money, to dollars and cents. On the right side of the prescription paper draw a perpendicular line from top to bottom. This decimal *line* takes the place of all the decimal *points*, and obviates the possibility of mistakes. This is the way dollars and cents are separated on business papers. Additional security is gained by writing the decimal fraction [centigrams] of half-size and raised above the line [of grams], since it represents a numerator of which the denominator, 100, is omitted. To make assurance doubly sure, "Grams" may be written over the integer-column of figures, and, if wished, the word "decimals" over the decimal column.

Now, what is a Gram ? or rather, the values, metrically expressed of our present awkward weights ?

		Prussian.	Practical.	Precise.
Grain	I =	0.06	0.06	0.065
℥	I =	1.25	1.25	1.29
℥	I =	3.75	4.0	3.89
℥	I =	30.0	32.0	31.1

The "practical" table alone concerns us. The "Prussian" [by order of the Prussian Ministry, Aug. 29, 1867] is given merely to show that our table is even nearer the actual truth than one which has been proved by actual experience to answer every purpose. The values of the grain and scruple are a little too small. As they are used for powerful drugs this is an error in the right direction. The values of the drachm and ounce are



a trifle too large, but the proportions, and therefore the ratio of drug to vehicle, are preserved.

A prescription written metrically is always proportionate, and whether the pharmacist uses pennyweights, pounds, or tons; gills, pecks or chaldrons; pints, gallons or hogsheads, the ratios are preserved, and a teaspoon dose contains the same amount of medicine.

As regards administration, a teaspoon represents five grams, a tablespoon twenty grams; for a teaspoon holds one and one-third fluid drachms, a tablespoon a trifle more than four times as much.

In the Metric System *everything is weighed*, thus obviating the difficulties of evaporation, refraction and adhesion, and obtaining more conveniently, more exact results. In our old "systemless system" some fluids were measured. How shall we obtain with weights the desired bulks of fluids with varying weights? Must we learn the specific gravities of all fluids?

*Not at all!*

1. Fixed oils, honey, liquid acids and chloroform, must at present be prescribed in our old weights, not measures, according to the pharmacopœia. Here change old weights to metric ones.

2. Not enough chloroform or ether is included in any one prescription to admit of harm arising from the amount contained in a single dose, even were their weights regarded as the same with that of water. Moreover, it is not difficult to remember that ether weighs seven-tenths as much as water, chloroform twice as much as ether.

3. There remain infusions and tinctures, glycerines and syrups. These four are used in bulk as doses, or as solvents or vehicles. The former two may be regarded as identical in weight with water; the latter two as one-third heavier, and when prescribing these we need merely write, by weight, for four-thirds as much as we should write for were we prescribing water, and we obtain an equal bulk. The teaspoon or tablespoon dose will then contain the desired amount of the drugs employed.

Or, simplest of all, we can make any mixture up to any desired bulk by merely directing the druggist to use enough of the vehicle to bring the whole mixture up to the requisite weight for that bulk.

The Metric Bureau, 32 Hawley Street, Boston, will furnish metric prescription-blanks to order, to druggists or physicians at four-fifths printer's rates, or any blank can be made sufficiently metric by a perpendicular line at the right, headed *Grams*.

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## AMERICAN DERMATOLOGICAL ASSOCIATION.

The next regular meeting of the American Dermatological Association will be held at Saratoga Springs, New York, on August 27th, 28th and 29th. The following is a list of the papers to be read.

The President's Address.

By JAMES C. WHITE, M.D., of Boston.

The pigmentary syphiloderm.

By I. E. ATKINSON, M.D., of Baltimore.

A new method of permanently removing superfluous hairs.

By L. D. BULKLEY, M.D., of New York.

A case of the so-called xeroderma Hebra.

By L. A. DUHRING, M. D., of Philadelphia.

A case of an inflammatory fungoid neoplasm of the skin.

By L. A. DUHRING, M.D., of Philadelphia.

A case of scleroderma.

By F. P. FOSTER, M.D., of New York.

The use of rhus toxicodendron in phlyctenous affections.

By GEO. H. FOX, M.D., of New York.

The treatment of hirsuties.

By W. A. HARDAWAY, M.D., of St. Louis.

On epithelium and its performances.

By C. HEITZMANN, M.D., of New York.

Idiopathic cutaneous atrophy.

By JAS. NEVINS HYDE, M.D., of Chicago.

A case of gangraenopsis.

By H. G. PIFFARD, M.D., New York.

Linseed oil as a therapeutic agent in diseases of the skin.

By S. SHERWELL, M.D., of Brooklyn.

A further contribution to the study of the xeroderma of Hebra, or teleangeiectasis pigmentosa et atrophica.

By R. W. TAYLOR, M. D., of New York.

On recurring scarlatiniform eruptions.

By R. W. TAYLOR, M.D., of New York.

A case of an ulcerative scrofuloderma.

By A. VAN HARLINGEN, M.D., of Phila.

R. W. TAYLOR, M.D.,

SECRETARY.

"Brevity, indeed, upon some occasions, is real excellence."

—CICERO, BRUT. 13.50.

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# ARCHIVES OF DERMATOLOGY.

OCTOBER, 1878.

Original Communications.

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## A NEW METHOD OF PERMANENTLY REMOVING SUPERFLUOUS HAIRS.\*

BY L. DUNCAN BULKLEY, A. M., M. D.

*Physician to the Skin Department, Demilt Dispensary, New York; Attending Physician for Skin and Venereal Diseases, at the New York Hospital, Out-Patient Department; &c.*

IN the following brief communication I wish to bring forward a method of permanently removing superfluous hairs, which I devised over two years ago, and which I have employed with a success which warrants me in announcing the method, that others may employ it as well.

It is well known that the ordinarily recommended depilatories have but a transient effect (except, perhaps, in very rare instances), and for the reason that they act only on that portion of the hair which is external to the follicle; or at the most they penetrate but a little distance into it, and necessarily cannot reach the bottom of the follicle, where the hair takes its origin. In the hope of giving relief to the deformity of hair upon exposed situations in females (who are often almost frantic from its presence) physicians as well as patients are frequently led to try, not only the depilatory remedies recommended in the books, but the various quack

\* This paper was written to be read at the second annual meeting of the American Dermatological Association, August 27, 1878, but the writer failed to return from Europe in time to attend the meeting. Since it was written abstracts of the proceedings of this meeting have been published in the *Boston Medical Journal* and in the *New York Medical Record*, in which allusion was made to this method of treatment by Dr. Duhring, who had employed it at my suggestion. Mention was also made of other methods of treatment, including the electrolysis, but no results were stated.

remedies, only to find that the effect of each is transitory, and that the hair reappears, causing even more distress than before.

I have long made trial of very many of these chemical measures for removing superfluous hair, both those of the books and those of the shops, and have so uniformly found them to fail in producing any permanent results that I have ceased to advise their use, except as palliatives, or as substitutes for shaving with the razor, or epilation, and I have repeatedly sent away patients who consulted me without being able to give them much if any encouragement as to permanent freedom from their disfigurement. Nor do recent authorities afford any more hope. The universal opinion is that the only relief is from the repeated removal of the offending hairs, either by continual epilation, or by the frequent use of a depilatory, or by shaving. All of these procedures tend to make the returning hairs larger and coarser, and consequently more objectionable. With some skins depilatory pastes act unpleasantly, by inflaming the surface, and they nearly always render it harsh, and more or less scaly.

Sometimes patients themselves attempt more radical measures, and the lady on whom I first used my method, indeed for whom I devised it, has a number of black spots on the chin, which are the result of her previous attempts to destroy the follicle by a needle heated in a lamp, the soot being deposited in the skin, and forming an indelible tattoo.

Two or three physicians have recently mentioned to me a plan of destroying the hair follicles by means of electrolysis, inserting in it a needle attached to one pole of a battery, while the other pole touches the body at some indifferent point. I am not aware that this method has been mentioned in print, nor do I know how successful or permanent the results have been. I have tried this in combination with my method, but did not find that any advantage was gained over that with the needle alone, while there was certainly much more pain given, and the additional complication of a battery rendered the procedure somewhat more annoying.

My present method, as mentioned, was devised over two years ago at the urgent solicitation of a young lady who had been under my care some time, and had tried the various depilatories in vain, but who still was not willing to give up the undertaking. I have since that time employed it on four private patients, ladies, aged 23, 24, 25 and 30 years respectively; but as two of them were treated for superfluous hair both on the chin and upper lip, we may fairly count them as six cases. The hair, then, in the six cases was located, three times on the upper lip, twice on the chin, and once in the form of a large hairy nævus on the right cheek.

The method to be described is founded upon the idea of reaching down into the follicle, after extracting the hair, and thoroughly breaking up its bottom and sides, thereby exciting an

inflammation which seals it from its base to its orifice. This is accomplished in the following way: A small, three-sided, straight, surgical or glover's needle is firmly inserted at its blunt extremity in a convenient handle; the smaller the better. The one which I use was made for holding a needle to be employed in manipulating microscopic preparations. The edges of the needle should be sharp, and may require grinding, even when new. A good pair of epilating forceps are also required; their edges should be well fitting, and such as will not cut the hair, and the spring should be rather weak, that it may not tire the hand unnecessarily.

The needle in its holder being taken in the right hand, as one holds a pen, a hair is seized with the forceps in the left hand, and the point of the needle is engaged in the orifice by the side of the hair, before the latter is extracted. Gentle traction is then made upon the hair, and at the same time slight pressure upon the needle, and as the former slips out the latter readily enters the follicle for a little distance. It is then thrust in, to a little greater depth than that occupied by the hair, as shown by the root-sheaths on the extremity of the latter, and with a delicate touch it may be readily perceived when it has gone to the bottom, or rather when it has penetrated the latter a little, and its sides are closely embraced by the follicle. A little experience soon shows this, and the error can be made of not having the needle penetrate deep enough far more easily than that of going too deeply. A clean needle can do little if any harm even when piercing the entire thickness of the skin.

When the needle is fairly in the follicle, it is given a number of turns or twists, by rotating the handle between the thumb and forefinger, and when it is withdrawn the sharp edges of the needle are seen to be filled with epithelial debris scraped from the sides of the follicle, and very shortly after a drop of blood or serum is seen to issue from the orifice of the recently irritated follicle. Occasionally blood will follow immediately, and if is not controlled, in considerable quantity, but this need never give trouble, for it is readily arrested by firm pressure with the finger, with a little ordinary picked cotton or styptic cotton. I have considered it better when but a little blood followed the needle, or when only serum was observed after a few moments, because when there is a larger flow of blood it indicates rather that the needle has missed the follicle, and either gone one side of it, or penetrated its walls, and has failed to reach the bottom, where the new hair takes its origin; though of course it is quite possible to penetrate through the base of the follicle, and pierce a little artery below. In by far the larger number of insertions of the needle I do not draw any blood, but only observe the serum exuding soon after each puncture.

At first, in order to make sure of exciting inflammatory action, I dipped my needle in carbolic acid before each insertion. Later I have repeatedly omitted it. I am not quite prepared to

say that some such agent is not useful, though I believe that I have prevented the return of very many hairs without employing it. It certainly does excite much more inflammation, and the irritation from each operation lasts much longer with than without the carbolic acid. The burning pain for a few hours after its use is considerable, many-fold that left by the simple puncture without it; perhaps a weaker solution of carbolic or of chromic acid would answer. It certainly is an additional protection against doing injury by the operation, in the way of conveying poison on the needle. It might be well to bear in mind the possibility of "tattooing syphilis" by means of these punctures, if the needle by any means retained any blood from a previous patient who had syphilis. The operation is not very painful. Ladies readily endure it. The surface may be dressed with a little weak zinc ointment or lotion, or lead and opium wash, if there is much irritation. There is no appreciable scar left when all inflammatory action has subsided.

Though the procedure here described appears to be perfectly simple, it will require often no little tact and patience to carry it through successfully, to a complete removal of the deformity. When the operation is first tried it will be found that the needle by no means enters every follicle at which it is aimed. Perhaps I am safe in saying that not fifty per cent. of the hairs removed at an operation will be permanently extirpated. In some instances a false opening will be made in the skin very close to the hair, and when the hair regrows, and the attempt is made at it again, the needle will again slip into this false hole, and this may be repeated more than twice. Again, often two or more hairs will be extracted by the forceps at one time, when only one of the follicles is or can be entered by the needle; or again, the needle may not have penetrated deep enough to destroy the base and the papilla, or the inflammation excited may not have been active enough to close the follicle.

Occasionally it will be found that the inflammation has sufficed to cause the external portion of the follicle to be obliterated, while the deeper portion where the hair is formed still remains intact, or nearly so. In this event a hair is reproduced, and not being able to gain exit, it will coil itself up, or it may run beneath the surface of the skin for a distance, and cannot be gotten at without a puncture of the overlying cuticle. In these cases it is often very difficult to reach and destroy the whole of the follicle, but it can be accomplished with care.

One will be surprised at the number of hairs which exist upon any surface when they are called on to remove them one by one, a fact constantly observed when epilating for parasitic diseases, and much more patent when each follicle is to receive subsequent treatment. In entering upon this measure, therefore, the patient should be fully acquainted with the fact that patience will be required, and that the deformity is not to be removed in one, two

or three sittings. It is difficult to treat much more than from twenty-five to forty hairs at a sitting; the eyes,\* hands and nerves of the operator give out, and the patient is generally quite willing to have the operation cease. In the cases which I have mentioned I have operated in all together fifty-seven times, and, while all the patients are very greatly benefited, indeed the deformity largely removed, there are still a number of hairs, which reappear or develop anew, and which are still being treated. Two of the patients live out of town, and have been irregular in attendance. This development of new hairs, that is the growth of smaller into larger ones, must be ever borne in mind, for, of course, such a procedure as is here described cannot in any way hinder such an event.

In regard to the permanency of the results, this is demonstrated most satisfactorily in these patients. In the lady on whom it was first performed, nearly two years ago, the hairs remain absent. In the second case hairs which were removed nearly a year ago have not returned, and the other two cases, which were first treated six and four months ago, demonstrate the same,

Considering then the failure of depilatories, and the intense distress which these abnormal growths of hair often occasion, and the successful results in these cases, together with the correct principle on which the operation is based, it may, I think, be rightly presented to the profession as a safe and reliable method of permanently removing superfluous hair.

## ON SO-CALLED "ECZEMA MARGINATUM,"

BY TILBURY FOX M.D., F.R.C.P.

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ENGLISH practitioners have become familiarized of late years with the term "eczema marginatum," which has been applied unhappily to a vegetable parasitic disease of the skin, affecting in a special manner the fork of the thigh and contiguous parts, particularly in tropical regions.

I have recently had under my care some interesting examples of the disease, and am anxious, whilst the facts of these cases are fresh in my mind, to make some general observations upon the malady, with the view of removing certain erroneous opinions which exist as to its nature, clinical history, and treatment. Some of my severer and more chronic cases came from South America,

\* I have used the unaided eye in making these operations, having tried in vain to find some method of magnifying the surface by lenses. Each attempt seemed rather to hinder than to assist.

Barbadoes, India, and the Straits of Malacca, respectively\* ; but in addition I witnessed during the last year the origin and progress of a *miniature* epidemic of the disease in six members of a particular family, and in a seventh person, a friend staying in the house of the latter for some time. During a period of several months, but of course not at the same time in all the instances, the father, three sons, a daughter, a valet, and the visitor were attacked. The first who exhibited the disease were the three sons, much about the same date, and the groin and axilla were the parts of the body where the disease showed itself. In one of these the malady, which presented in this case when first observed, typical features, was complicated by eczematous inflammation and lasted three months. In one a return of the disease was observed after an apparent cure. The daughter was affected in the groin, the axilla, and about the arms and neck, and by small patches of *tinea circinata* over the latter. The friend had the disease typically, and in him it was easily cured. He was attacked fourth in order. The valet was attacked last but one in order of succession, after three of the sons had got well, and he had it severely. It was complicated by eczema secondarily, but it is probable that this was excited by the freedom with which the remedies were used, together with the scratching. The head of the family was attacked last of all, and in his case the disease was quite typical at first, consisting of a single patch with well-defined papular edges festooning down over the thigh, but this was succeeded by severe eczematous inflammation of the thighs, groins, scrotum, and perineum, which lasted a good many weeks, was very obstinate and troublesome, but was cured at last by local remedies. These particulars alone suffice for the purpose I have in view.

As regards the correctness of the diagnoses in these cases, it is hardly necessary to go into detail. The microscopic examination disclosed the presence of the fungus usually found in the disease. In all these cases the disease began by red circular spots (not eczematous at all) in the fork,—which speedily assumed the ringed or marginate form—festooned down over the thigh a greater or less distance—the central portion becoming lighter in color and slightly desquamative as the disease progressed. The itching was very troublesome, though intermittent. In all but one instance the disease was limited to the fork and the axilla, the former alone or both together. In the exceptional case it attacked the neck and arms, but in this case the disease was rapidly cured by local remedies. In three it was succeeded or complicated by eczema. In no case did the disease begin as eczema. The evidence of direct infection could not be obtained with positiveness ; the valet got the disease soon after wearing the lower clothes of one

\* Dr. Bulkley, of New York, has recently (Chicago Medical Journal and Examiner, November, 1877,) written "On the so-called Eczema Marginatum of Hebra, as observed in America," in which he details twelve cases, and demonstrates their parasitic character, applying to them the name "*tinea circinata cruris*." The disease appears to assume a milder form in America.



of the the attacked. I could not trace the original source of the malady, but could only suspect that it was spread through the laundry in some way ; but this was only conjecture. The disease was readily cured in five out of the seven cases and obstinate in the two severer ones. I have not hitherto met in my own practice with a similar set of events, which are interesting from their occurrence in connection with persons who have not contracted the disease out of England, and in which it is not therefore of oriental, but of home origin. Of course I have seen other solitary instances of "eczema marginatum" of non-tropical origin.

The three other cases I mentioned as having come home lately from tropical parts were all more severe, and in fact would have been called severe and intractable instances of the disease in the tropics. There was more inflammation of the affected parts, a deeper color, more congestion, and a larger extent of surface involved than in the simple or home example of the malady, which is not difficult to understand. The particular part I wish to note about them is the absence of any true eczematous inflammation. It was impossible to regard the disease in these three old standing cases as eczematous. I could understand anyone regarding the disease as syphilitic but not eczematous.

In a special report\* Dr. Farquhar and I have given the substance of the information received from some forty and more medical men practicing in tropical parts, relative to the ring-worm of hot climates. The reporters agree in a remarkable manner as to the nature, features, and cause of the disease as they have observed it. In the document in which we originally asked for information from the reporters, we described "eczema marginatum," and stated that in our experience the oriental ringworm and it were one and the same disease, though the features in particular cases might vary in severity ; and we further noted that this "eczema marginatum" and the oriental phase of ringworm known as Indian, Chinese, Burmese ring-worm, and Dhubie itch, etc., to be modifications of the *tinea circinata* or common body ringworm of European authors, produced by climate and other differences. As I have said, the reporters above mentioned entirely concur in this view.

Such facts as those of the miniature epidemic I described at the outset of this paper, with others I have from time to time observed in connection with instances of the so-called "eczema-marginatum," which have occurred singly in my practice, and in addition the mass of data contained in the report of Dr. Farquhar and myself, leave no doubt in my mind that the following propositions are incontestably true :—

*First.* That "eczema marginatum" is not an eczema at all, but a true *tinea* or vegetable parasitic disease, though it may be

\* On certain Endemic Skin and other Diseases of India, etc., by Tilbury Fox and T. Farquhar. Published under the sanction of the Secretary of State for India, in Council, 1876. Churchill & Co.

*complicated* by eczema ; that "eczema marginatum " mostly exists without any eczema ; that eczema when it is present as a complication, is the *secondary* result of the irritation of the fungus or the scratching practiced to relieve the irritation ; that the occurrence of eczema as a super-addition is favored by the peculiarities of the commoner locations of the disease, *i.e.*, the axilla and the fork, where friction, heat, and moisture are more operative than over the general surface of the body ; and lastly, that eczema of the fork and axilla often occur as an independent condition.

I put this proposition in definite terms, because it is still held by German authors that "eczema marginatum " is essentially a compound of eczema and herpes tonsurans. The concurrence of the two conditions is a different thing from identity in nature. The origin of "eczema marginatum " is by a red, itchy spot, which rapidly enlarges with a well-defined, raised, papular edge, and a speedily acquired desquamating central portion.

*Second.* That the extent and severity of the disease vary greatly in different cases. As regards extent : In non-tropical parts the disease is often limited to the fork of the thigh or the axilla, or both. In tropical regions it often spreads to various parts of the body covering even large tracts of surface as, for instance, the buttocks or the shoulder region. But, though this is usual, *the slighter and more localized forms are seen in abundance in oriental parts*, according to the testimony of all observers, and the more extensive form may very occasionally be seen in England. As regards severity, the disease may be slight, and consist of small patches only, even in tropical parts.

I specially mention this latter circumstance because of counter statements. These assertions are abundantly proved by the facts in the report of Dr. Farquhar and myself.

*Third.* The naked-eye characters of the disease naturally vary with its intensity. In oriental countries the fungus, on account of the influence of greater heat and moisture about the skin of the affected parts, is more abundant and luxuriant ; hence the more rapid spread of the disease, the greater degree of irritation induced, and the marked amount of infiltration and congestion in connection with it. But the correctness of the statements made under these last two heads comes out more strong in the light of therapeutic results in so-called "eczema marginatum," for the variation in the degree of curability of different cases of the disease in tropical, as well as non-tropical regions is remarkable : this is the universal experience of Indian medical officers.

This difference in the severity of "eczema marginatum " is no new fact in the history of vegetable parasitic diseases. It is exemplified abundantly in common scalp ringworm, and indeed in ordinary tinea circinata or body ringworm in England. It is illustrated in a remarkable degree in the case of body ringworm contracted from cattle, in which, with a greater luxuriance of fungus, the tinea circinata in the human subject is often severe, and con-

sists of large, swollen, infiltrated, well-defined patches, studded over with what seem to be suppurating points, and which are indeed the several inflamed follicles, constituting a parasitic sycosis, in fact; whilst, as showing that the condition is only an exaggeration of common *tinea circinata*, typical spots of the latter may be present in the same subject, together with transitional phases between the slightest and the severest patches, the exaggerated patches beginning in fact as ordinary *tinea circinata*. I have recorded cases of this kind from contact with the horse suffering from ringworm, in the *Clinical Society's Transactions*, Vol. IV. In September of the present year (1877), I saw with Dr. Althill, of Faversham, a number of cattle just imported from Ireland, and suffering from ringworm, who had infected some half a dozen men whose duty it was to attend to the cattle, and in whom body ringworm was produced about the hands, arms, and face, varying in severity from patches having the exact character of simple, typical *tinea circinata* (body ringworm), to large, swollen infiltrated pustulating patches, which in one case was thought to be a carbuncle, and was opened accordingly. I mention these facts briefly, to prove how much *tinea circinata* of the body varies in its degree of severity, and therefore in its aspect, in connection with the varying luxuriance of the fungus.

As to the explanation of the cause of this variation in the aspect and obstinacy of "eczema marginatum" of tropical countries I have little to say now. I merely deal with the fact. Climatic considerations, the state of the general health, the ineffective application of remedies, the unusual luxuriance of the fungus, the lodgment of the parasite deep in the hair follicles out of the reach of remedies, and constituting there so many sources of future recurrences of disease, have most influence. The exact reason why the axilla and fork of the thigh are specially the seat of the disease is a difficulty with which I am not now specially concerned. There may be something in the secretion of these parts favorable to the parasitic growth. All that I desire in reference to these two last heads to do is, to explain that the disease under notice varies infinitely in its extent and the degree of its severity, and less so in regard to its naked eye features.

*Fourth.* The term "eczema marginatum" is a most inappropriate one and should be given up. The fact is that Hebra applied the term at a time when he was in entire ignorance of the parasitic nature of the disease, and therefore it was used under an entire misconception, and its use should therefore be relinquished. Besides, it is unnecessary since the disease is included under the generic term for vegetable parasitic diseases of the skin, viz: *TINEA*, and the appellations *cruris*, or *axilla*, or *tropica* sufficiently indicate the seat or character of its several phases.

Such are the main points to which I wished to direct attention. They are elementary it is true; but a necessity for re-

stating them has been created by recent contributions to the subject. But there are in addition two other topics ; the one relating to the character of the fungus in *tinea circinata tropica*, and the other, the degree of contagiousness of the disease ; which deserve a few comments.

The luxuriant growth of mycelium is remarkable in the tropical ringworm of the body. It is not a special fungus, but a modification of *trichophyton*, and it is easy to show that the transition from the more usual to the more luxuriant state, characterized by large, freely branching and jointed threads, may readily take place ; for in the instance of the production of onychomycosis from contact with *tinea tonsurans*, the trichophyton implanted beneath the nail, when it goes amid the strata of the latter, assumes the exact characters of the fungus of tropical ringworm. If anyone will take the trouble to compare the fungus of Dhobie itch as I have figured it in the report of Dr. Farquhar and myself, with representations of the fungus of onychomycosis, he will have his mind assured upon this point.

In the matter of contagion, it has been said that "eczema marginatum" cannot well be common ringworm, because it is not very contagious, and particularly because husbands do not communicate it to their wives. I am not prepared to endorse the latter part of the statement ; I think I have observed the contrary, and I believe wives *may* and *do* take the disease, and use the same treatment as the husband, whilst the facts are concealed for very obvious reasons from the medical man. But be this true or the reverse, it seems to be forgotten that common ringworm, though very communicable from child to child, is not by any means commonly conveyed directly from child to the adult, and rarely so, from adults to adult. The *tinea circinata tropica* is a matter which concerns the adult, and it only follows the general rule in this respect. Indirectly no doubt, through the intermediate influence of clothes, the laundry, etc., the communication does take place. At any rate it is no valid argument to say that the typical form of ringworm is not the same in nature as *tinea circinata*, because it is not freely communicated between those living together. Another instance in which a *tinea* is not communicated from husband to wife, or *vice versa*, though there may be abundance of fungus present is in *tinea versicolor* ; something more than mere contact is needed *in the adult* to ensure contagion.

**Note on treatment.**—I have not experienced, even in severe cases, the difficulties in curing instances of "eczema marginatum" met with by some writers who have recorded their experience in the matter.

In a large proportion of the cases met with in India, the application of the now popular and fashionable goa powder, suffices to remove the malady. It may be necessary to apply the pure powder twice or thrice, taking care not to irritate the parts too

much ; or an ointment made of from fifteen to thirty grains of the powder to one ounce of lard may be used.

An equally good remedy is a hyposulphite of soda lotion freely applied two or three times a day, and allowed perhaps to remain in contact with the surface for half an hour at a time, by means of a fold of lint wetted with the lotion. The parts should be carefully washed free from their normal fatty matter with soap and water before the lotion is used. If it in any way irritates, a little dusting powder may be applied after each use of the lotion. It is also important that this wash should be continued for a week or ten days after all appearance of the disease has vanished, lest the germs of the fungus be left behind, and reproduce the disease upon a disuse of the remedy. The addition of sulphurous acid solution to the hyposulphite lotion assists the latter in its operation. I think it may with certainty be said that relapses are frequently the result of a too speedy relaxation in the employment of parasiticides.

In the more chronic and obstinate cases, the above indicated measures may fail to cure ; but then a list of remedies are available, such as linimentum iodi, acetic acid, nitrate of mercury ointment, Coster's paste, and such like. Perhaps as good an application is an ointment made of oil of cade, 3 iij., sulphur, 3 iij., sub-carbonate of potash, 3 j., creosote, twenty drops, and an ounce of lard. This should be freely rubbed in at night. It should be washed off in the morning when the sulphurous acid lotion (to the proportion of one to two or four parts of water) should be kept in apposition with the affected parts for some little time. It may be necessary to use more potent remedies still, and then vesicating colloid or Coster's paste, followed by the above mentioned ointment will prove efficacious. But different cases require varying treatment to meet the complications of eczema, swelling, crusting, infiltration and the like. Here as under other circumstances, perseverance with remedies, after all appearance of actual active mischief has vanished, is requisite.

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## ON THE TREATMENT OF PSORIASIS WITH CHRYSOPHANIC ACID.

BY J. T. STANSBURY, M. D.,  
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**A**LTHOUGH comparatively only a brief period has elapsed since Dr. Squire introduced Chrysophanic Acid as a remedy for Psoriasis it has already attained a wonderful reputation, and but for the fact that only digests of cases in which it was used have appeared in the pages of the *Archives of Dermatology*, I would not presume to record my experience. This is

necessarily limited, for my cases are drawn exclusively from private practice, and besides, I have only selected such as were remarkable for the duration and obstinacy of the disease.

Long ago I became thoroughly disgusted with arsenic—the panacea for all diseases of the skin—in the treatment of this affection, and although I have never seen a case of psoriasis that has not been treated with arsenic, I have yet to see, either in my own practice or that of another, a case that has been cured or even benefited by that drug. I know that this statement is in direct opposition to the opinions of some of the best known dermatologists in this country and Europe, nevertheless, my experience and observation compels me to make it. For several years I have treated psoriasis with phosphorous internally and acetic acid locally. This plan was quite successful and a number of cases recovered, but many although apparently benefited for a time, ultimately refused to “get well.”

In the early part of 1877, learning that Dr. Squire had met with remarkable success with chrysophanic acid, I determined to give that drug a trial, although I must confess that I had very little hope of obtaining similar results.

After obtaining a supply of the acid, several weeks elapsed before I met with a suitable subject for my experiment. However, on August 25th, 1877, I met with Mr. H. H., a gentleman who had formerly been under my care for the most inveterate psoriasis I have ever seen. I felt some delicacy in approaching him, for I was aware that he was as thoroughly disgusted with physicians as he was with his disease. After inquiring as to his condition and finding it unchanged, I told him that I had a new remedy and suggested that he should give it a trial. At this he laughed, but on the next day he called at my office, and told me that if I was sincere in my belief that I could effect a cure, he was willing to submit to treatment. His disease had existed for five and a half years, and during the greater portion of that time he had been treated with arsenic, phosphorous, tar, etc., but without benefit. For a year he has employed no treatment whatever. Upon examination I found him in pretty much the same condition as when last seen. The knees, elbows and forearms were extensively covered with the well-known “mother-of-pearl like” scales of psoriasis, but no new spots had developed for some time. To soften the patches, cosmoline was applied for several days, and the scales afterwards removed with the edge of a dull knife. After this chrysophanic acid ointment (gr. 90 ad  $\frac{3}{4}$  i) was applied twice a day. Excepting one or two doses of acetate of potassa, this was the only treatment employed. The result was almost magical, for within five weeks, Mr. H., had entirely recovered, and up to the present writing his disease has not returned. The only disadvantage of the drug was the slight yellow stain left for some time after its application, but even that has now disappeared.

On September 28th, 1877, another patient with psoriasis who

had submitted to the phosphorous and acetic acid treatment for six months without permanent benefit, was induced to try the chrysophanic acid ointment (gr. 60 ad  $\frac{3}{4}$  i). His disease was located on the back, thighs, legs and extensor surface of the forearms, and had existed for several years. The patches varied in size from a ten-cent piece to a half dollar. The ointment was applied twice a day, and the patient recovered within eight weeks. This patient having neglected to protect his hands when applying the ointment had his nails badly stained, he also suffered with considerable irritation of the eyes. Thus exhibiting the bad as well as the good effects of the remedy. Up to the present time this gentleman has had no return of his disease. While the above patient was still under treatment, he requested me to see his relative, Miss M., a young lady 22 years of age, who had psoriasis since she was six years old. During the greater portion of this long period she has been under treatment both in this country and Europe, but with only temporary benefit. Upon inquiring if she had taken arsenic she replied that she must have taken "pounds of that remedy." When I saw her she had a copious eruption on both forearms, a patch on the left knee about the size of a twenty-five cent piece, and another a little larger on the outer surface of the right thigh. As my first case had entirely recovered, and my second was rapidly improving, I felt little hesitancy in telling her that I thought a cure probable, provided she would carry out my directions. This she promised to do, and on October 15th, 1877, I ordered chrysophanic acid ointment (gr. 60 ad  $\frac{3}{4}$  i) to be applied twice a day, rubber gloves to be worn when making the application. In two weeks the patches on the lower extremities had disappeared and within five weeks her arms were free of the disease. I saw her in May last, just before she sailed for Europe, and she was then quite well. Recently I have treated two other cases with equal success, but as they were very much milder than my first cases, and such a short time has elapsed since they were under observation, I will only mention them now, preferring to await "further developments" before adding them to the list of cures. As yet I have met with no case in which I thought it advisable to employ an ointment of greater strength than 90 grains to the ounce of lard, and in many cases a less quantity will prove equally efficacious, while it has the advantages of economy and the ease with the strength may be increased. I think 30 or 40 grains sufficient for most cases. The ointment should be made by dissolving the acid in *hot* lard, and rubbing in a mortar until cold.

In none of my cases was the disagreeable tingling of the skin mentioned by Dr. Squire as produced by this remedy, complained of.

As yet I have not met with a single failure, but I can readily conceive that such will not always be the case, and he who expects to cure *all* his cases of psoriasis with chrysophanic acid, will be most grievously disappointed. Besides like all new and valuable reme-

dies it will be no doubt greatly abused. But when the cases are properly selected and the remedy judiciously employed, the failures I think will be few. It is in those old chronic cases that have resisted all other remedies that chrysophanic acid achieves its most brilliant results.

## ON THE PROPER USE OF THE TERM "ACNE,"\*

BY GEO. HENRY FOX, M.D.

THE title of this paper implies that there is an improper use of the term acne.\* This is evident to anyone who considers its variable signification, and admits that precision of statement must depend upon the use of definite terms. In a general sense the term acne is well understood, but as its strict definition has been slightly varied by nearly every writer since Willan, the term is now employed in such a careless way that it is a difficult matter to decide what is and what is not acne. Dr. Duhring, in his text-book, agrees with Hebra in defining acne as an inflammatory disease of the sebaceous glands, and classes seborrhœa and comedo as distinct affections. Dr. Piffard, in his book, like the majority of French writers, includes under the head of acne nearly all affections of the sebaceous glands. The so-called *acne-rosacea*, however, he regards as a separate affection. This discrepancy in the use of the term acne may seem to be of little importance, but I believe no better work can be accomplished by those interested in Dermatology than in an effort to promote harmony in the use of terms throughout the profession.

The variable use of the term acne is a natural outgrowth of the varying systems of classification. Thus, from an anatomical point of view, acne is associated with disorder of the sebaceous glands, and the name is used as a generic title for all or nearly all glandular affections. From a pathological point of view acne is classed with the exudative diseases, and the term is restricted in its application to an inflammatory condition. Again, from a lesional point of view the term is applied to all eruptions of small, disseminate, follicular pustules with indurated base, occurring on various portions of the body, and resulting from a variety of causes. Finally upon purely clinical grounds the term may be applied to a definite affection of the skin possessing numerous and well-marked characteristics.

To my mind it seems most convenient, as well as most appropriate, to restrict the application of the term acne to an inflammatory condition of the sebaceous glands. It is true that functional disorders such as seborrhœa and comedo are commonly associated with the inflammatory condition, yet these affections often occur alone, and there exists no necessary connection be-

\* Read before the American Dermatological Association, August 27th, 1878.



tween the two. Moreover, the use of the terms *acne oleosa*, *acne punctata*, *acne miliaris*, etc., does not convey to the mind a clear idea of the patient's condition. *Acne oleosa* may mean an oily skin without inflammation of the follicles, or a crop of inflamed papules with the slight greasiness of skin so frequently met with in *acne* patients. *Acne punctata* may refer to a few comedos, or to a well-marked inflammatory affection of the glands. *Acne-miliaris* suggests both the small whitish pin-head papules, occasionally mingled with comedos in a case of *acne*, and the hard, cheesy, subcutaneous tumors occurring upon and near the eyelids, which are rarely if ever associated with glandular inflammation, and which have no more connection with the papules and pustules of *acne* than have wens, which, according to this system of nomenclature, ought to be called *acne atheromata*, or *acne steatomata*. How much better to use the terms *seborrhœa*, *comedo*, *milium*, and *acne*, each of which conveys to the mind a distinct idea! And when a patient happens to suffer from two of these affections in a marked degree, which is very unusual, then it will be worth while to make a double diagnosis.

But, it may be urged, a *comedo* is merely the first stage of an *acne* pustule. To this I must dissent. Notwithstanding the frequency of the assertion, *comedo* is not the starting point of *acne*, or, in other words, the cause of the inflammation. Comedos frequently exist upon the face in great number without occasioning any glandular irritation, and *acne* pimples or pustules often develop in connection with glands in which there is no excessive accumulation of sebum. The immediate cause of the inflamed *acne* papule I hold to be a disordered vascular supply, akin to the vasomotor paralysis which produces the wheal of urticaria. *Acne*, like urticaria, is a disease of internal origin, although I will not deny that an over-distended duct or gland may determine the seat of congestion just as a slight scratch or other irritation of the skin may determine the site of the wheal in urticaria.

The terms *acne vulgaris* and *acne indurata* are convenient and expressive, and it would subserve the interests of dermatology, I think, if the varieties of *acne* were limited to these two. *Acne syphilitica* is a term which has long been in use and is still in use by those who prefer to name the lesion rather than the disease. In this country, however, thanks to the precept and example of a few, this term with others of its class is fast falling into disuse, and the term *pustular syphilide* or *syphiloderm* is used in its stead. Iodic *acne* and bromic *acne* are terms which are often applied to the pustular eruption resulting from the internal administration of iodide of bromine. If the pustules produced by the syphilitic poison in the blood are not to be regarded as a form of *acne*, why should we apply the term to these medicinal rashes which have no more connection with nor resemblance to the pustules of *acne* proper? If we speak of *pustular syphilis* let us speak of *pustular bromism*, and, discarding the term *syphilitic acne*, let

us with it discard the the terms iodic and bromic acne. 'Tar acne' is a short and convenient term, and one difficult to get rid of now that it is in general use. At the same time the suppurative folliculitis resulting from the use of tar bears far less resemblance to true acne than does the suppurative folliculitis resulting from syphilis. In fact the general term acne artificialis is a misnomer, for true acne, as I have already claimed, is a disease of internal origin and it cannot be artificially produced.

There is still another pustular affection of the sebaceous glands which most of us have doubtless observed this summer in connection with or following an eruption of prickly heat. I refer to those small tubercles or pustules occurring on the face, scalp, hands, and body, which might be termed acne solaris or acne calorica, and probably will be if the tendency to apply the term acne indiscriminately be not checked. These pustules, which by the way are unmentioned in most if not all of our text-books, were well described by Bronson in an article on heat symptoms in *Archives of Dermatology*, January, 1877. They involve the sebaceous glands, and only differ from acne tubercles in exhibiting a tendency to phlegmonous inflammations. I have seen one or two cases where the face was affected by this pustulo-tubercular heat eruption, and the resemblance to acne indurata was such as might have led to an erroneous diagnosis. And yet a careful observation of this affection shows that these tubercles are furuncular rather than acneiform in character—and however they may resemble acne from an anatomical or pathological point of view, they are clinically distinct.

Let us now look for a moment at the affection called acne-rosacea. If this term refers to the hyperæmic condition of the face in young persons affected with acne, it is well chosen. But, as we all know, it is applied to an affection which commonly occurs in later years, and in which the sebaceous glands are often in a perfectly normal condition,—an affection which is not characterized by an exudative process but by a new formation of cellular and vascular tissue. In many cases we have simply diffused redness of the nose and cheeks with thickness of the skin from hyperplasia of connective tissue—a condition totally unlike acne, and to which a separate name should be applied. The term rosacea has been used alone in this connection; and I am convinced that students and physicians in general will gain a clearer idea of this affection (the distinct nature of which was pointed out by Hebra over twenty years ago) by applying a separate term to it instead of classing it as a variety of acne which it is not.

This forcing of the term acne to include so many distinct affections is calculated to produce confusion rather than to favor simplicity. Here is a striking illustration of the point: Every physician believes now (and is correct in his belief) that sycosis is an affection distinct from acne. But a confused notion of the two affections would most certainly have been the result had we re-

tained the old and improper term *acne mentagra*. So I contend that the confused notion which now exists regarding the nature of *rosacea* will disappear when the confusing term *acne-rosacea* is discarded.

## THE USE OF LINSEED\* AND LINSEED OIL AS THERAPEUTIC AGENTS IN DISEASES OF THE SKIN.†

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AT a meeting of the New York Dermatological Society, Jan. 29, 1878, I had the honor of reading a paper having title and subject almost identical with that which I now offer, and which was briefly summarized in the issue of the *New York Medical Record*, for April 13, 1878.

Having since fortunately had some interesting cases of skin disease, the histories of which to my mind sufficiently prove the value of the remedies advocated, averse as I am to the labor of writing, I could not but seek to reiterate my convictions before this body, show the results of treatment, and give in as brief a manner as possible, my reasons for the faith that is in me.

Every practitioner, and notably every dermatologist must, I think, have had cases, in which the exhibition of the fats and oleaginous foods to supply or replace wasted or absent adipose tissue, has been paramountly indicated ; and has had in some of them certainly to lament the fact that the one hydrocarbon most used, cod liver oil, has seemed to disagree with his patient, being not only repugnant to the taste and other senses, but as also leading to effects almost toxic in character, causing diarrhoea, eructations, and gastro-intestinal disturbances generally. Such has been my experience, and yet in many cases the individuals from their badly nourished and marasmic conditions have seemed imperatively to demand the administration of some more assimilable hydrocarbon ; hence I have been driven to look for such, and I believe I find it in linseed oil, given in the manner I shall notice further on.

I was led to the employment of this agent from observations on its use in fattening the lower animals to whom it is given in the form of the coarsely ground oil-cake. This linseed cake, as it is termed, is made by hydraulic compression of the recent meal, mixed with a little water and warmed : the oil is naturally thus expressed in great degree, still, sufficient remains with the albuminoid and other elements of the seed to form a most nutritious

\* *Linum Usitatissimum*.

† Read before the American Dermatological Society, Aug. 28, 1878.

food for animals, promoting in them a great increase of adipose tissue, and a remarkable lubricity of skin and of the epithelial appendages.

The use of this food is not confined to horned cattle, but horses are fed with it to some extent, and expert horse dealers know well its value for giving mangy-looking and bad coated horses a fictitious glossiness of coat for obvious purposes. It is used moreover for the omnivora and carnivora, dogs being treated in same way, for the same ends, as of exhibition, etc; it has however, a cathartic action on the felidæ, though often administered in the various menageries, it serves, say the keepers, to keep them in *good condition*.

Reasoning, then, from the general principles of nutrition, and these points of what may be called comparative physiology, it has occurred to me that use might be made of this article in the human economy for the production of similar effects, and experience has certainly to me demonstrated the truth of this theory.

Naturally, I do not give the cake, and but seldom the oil in its free state, though I have had cases in which it was preferred by patients in that form and without emulsification. My usual methods of administration are three-fold, any one of which may be elected by the patient as most convenient, or least distasteful.

*First Mode.* This is one which I like much, especially if patient be a male and has sound teeth : that is, for him to carry about with him, in pocket or other receptacle, a few ounces of the seed in its natural state, from time to time taking a convenient quantity into the mouth and masticating it thoroughly and swallowing. In this way quite an amount will be consumed in a day, the average individual probably will take an ordinary tea-cupful : it will be easily seen however, how the quantity may vary from day to day, from want of opportunity, diversity of occupation, etc. Estimating, as is just, that the seed of the quality I direct, contains nearly 30 per cent. of oil, we readily see how comparatively large quantity of oil may be taken in this way ; and as I believe, in the manner best adapted for assimilation, and unattended, as far as my experience goes, with the almost certain disturbance (gastro-intestinal), that would be caused by the ingestion of a considerably smaller quantity of cod-liver or other oils. I would here remark that the ordinary flaxseed sold by druggists is a dark, small, and hard variety, very different from that obtained from India ; Bombay, or Calcutta seed which I recommend, is nearly twice the size of that usually sold, and contains a much larger percentage of a sweeter and more palatable oil and pulp.

*Second Mode.* This is often more convenient, and for women, children, and invalids, is, I think, to be preferred. This is to prepare seed by grinding it somewhat coarsely in a little mill (in most houses there is a little spice or coffee hand-mill that will answer) ; an ounce or more of this meal stirred up with warm or cold milk, to form as it were a porridge, is readily swallowed as may be

fancied, and has little or none of the cold poultice-like taste or appearance that might be imagined ; as I have said before linseed is unpalatable to but very few persons.

*Third Mode.* This is when prepared in the form of bread ; it is an elegant and quite acceptable method, though after mature consideration I am not inclined to give it equal value with the methods in which the oil is taken in a recent form, unoxidized by heat, etc. This linseed bread may be made by mixing the meal with ordinary flour in any proportion, say from one to three-fourths, and is prepared in the same manner that ordinary bread is made. Dr. Piffard suggested this latter method, and at a meeting of the New York Dermatological Society, subsequent to my paper, brought one or two loaves for test ; they were, I believe both eaten up in the course of the collation after the meeting, their palatability being thus well proven.

I have used this means of nourishment in many cases with very satisfactory results, notably in one case of pityriasis rubra, occurring in a baker's wife. Naturally he exerted himself to excel, and produced an article of bread on which I have lunched once or twice, and which was certainly quite pleasant to the taste.

However, I still believe that the first two methods of administration are the best, as it seems reasonable to believe, that the fact of the seeds, by being thoroughly prepared for digestion by complete mastication and insalivation, are in condition to liberate the oil in the stomach for a perfect and physiological emulsification, as it passes along the "*prima viæ*," which I think better than any extra-corporeal emulsion however scientifically prepared. The vegetable albuminoids and gums contained in the seed have good nutritive properties, while the presence of the *exuviae* gently stimulates a torpid peristaltic action of the intestines. C

It is a well-known fact in organic chemistry that a recent oil is acted on differently, or more readily by various reagents than one that has stood some time, and possibly suffered oxidation to some extent, etc. ; experts in chemistry cannot explain the exact reason for their different behavior, except by referring generally to the protæic mutability and multiplicity of hydrocarbon compounds.

Theory then as I think, would favor a freshly liberated oil making its recompositions directly in the economy ; and even as to cod liver oil, I think more advantages would be secured by partaking of the liver direct, fresh and well cooked, and am in the habit of so ordering when circumstances allow. And in reference to cod liver oil, I might be allowed a short digression in order to state my extreme dislike for, and want of faith in all the commercial emulsions made. I may do some careful firms an injustice, perhaps, by so sweeping a condemnation, but I believe in any case that the more recent an emulsion is the better it is ; and that in a large proportion of said emulsions, they are rather saponifications, and possibly and probably of an inferior quality of oil. Then again, we have to consider the great risk of deterioration in quality

common to all proprietary mixtures, once their popularity is attained.

So far I have confined myself to the assertion of the general nutritive qualities of this seed and oil ; I now would make claim for its specific virtues on the skin, especially in dry and harsh, or irritated conditions, as in pityriasis rubra, ichthyosis, eczema, etc. I believe that, besides its general good effects in increasing the amount of adipose tissue this oil has a great and specific direction in favor of the sebaceous glands and that their secretion is increased and improved thereby, as is shown, after a short time, in the gloss of the hair, and the lubricity and flexibility of the epidermis itself. Whether the whole of its specific good effects may be attributed to this increase in quality and quantity of sebaceous material, I know not, but would accept that as a sufficient inducement for its use.

Used externally and alone, linseed oil is one of the most soothing applications I know of, it has not that tendency to decomposition or rancidity that *oleum morrhuæ*, and *oleum olivarum* so markedly possess ; this oil at most simply oxidizes and dries.

I will now give a brief resumé of four cases : two of pityriasis rubra, one of pemphigus foliaceus, and one of pemphigus vulgaris. To these might be added, one of xeroderma, three of ichthyosis, and very many cases of eczema, particularly old, inveterate eczema of the hand ; but I shall confine myself to the limits of the first four mentioned.

CASE I. *Pityriasis rubra*. Annie S., æt. 9. Father died of phthisis. No other history of diathesis in family, or evidenced by observation. Was asked to see her for an obstinate skin trouble, by Dr. A. J. C. Skene of Brooklyn, he taking interest in family.

Sept. 9, 1876. Found patient had been suffering some two or three months in bed, covered with the characteristic dry, scaly eruption from head to foot, literally not one square inch from vertex to sole being unaffected, and, as in the next case, I was told that she could be tracked from room to room by the scales falling off, from attrition of the clothing ; they could be taken up by the handful from the bed. To be brief, I used what I deemed appropriate as to constitutional treatment, iron, strychnia, the mineral acids, and sometimes Fowler's solution, but above and beyond all cod liver oil, both internally and as inunction, many gallons of this latter being furnished by Dr. Skene.

For nearly six months the case slowly progressed towards cure ; at length, on a hint from Dr. S. that cod liver oil was a somewhat expensive article I substituted linseed and linseed oil, internally and externally. The change for the better thereupon was rapid, and a complete cure followed in six weeks from the date of first using. It was this case that first led me to the perhaps extravagant estimate of the virtues of the *oleum lini* in marasmic conditions, which I still hold. She gained more flesh in the short time in which she used linseed oil, than in all the previous months.

She had a slight relapse about four months ago, commencing on the lower limbs and back of neck and head. It yielded

quickly to the same treatment, and she is now a well nourished, healthy looking girl.

CASE NO. II. *Pityriasis rubra*. Mrs. B., æt. about 32; husband, a wealthy baker. No diathesis apparent from history or otherwise. She has two uncommonly healthy children, one an infant of about seven months at the time of my first visit, April 11, 1878.

Patient exhibited a marked case of pityriasis rubra, being covered from scalp to foot with a dry, scaly eruption seated on a non-infiltrated skin, leaving here and there a very few small portions of the body unattacked, those perhaps more toward the flexor surfaces, but not markedly so. The eruption first commenced on the cheek, just below the eye. She has been under treatment regular, irregular and composite since its first appearance, about six months since, the trouble ever increasing. Her husband assured me, seemingly without exaggeration, that he was able to trace her path anywhere about house by the scales she dropped, and that in the bed a handful might be taken up at a time.

She was placed immediately on linseed bread and porridge internally, and a thorough and profuse inunction with the oil, also slightly alkaline baths at night, after which the inunction was renewed; a mask of linen, soaked in oil, was used on face at night.

In this case also at different times tonic medication was given, such as iron, quinine and the mineral acids in small dose; also a little arsenic for a short time, which was quickly stopped however. To relieve pruritus she was occasionally allowed to use soothing lotions as that of the emulsio amygdal. amar., and acidum hydrocyan. dil., and oil of cade with ol. amygdal. dulce, etc; this mainly toward the end of the treatment.

In three weeks from the commencement of treatment she was able to attend church unveiled, and her cure was effected to her own satisfaction about the middle of June, there being still a very slight furfuraceous desquamation in some parts, which was steadily lessening. She still continued, though not in so uninterrupted a manner, her linseed bread, which she relished as at first. She gained considerable flesh, though I cannot state how much.

CASE NO. III. *Pemphigus foliaceus*, with relapse. Mary Richt, æt. 8½. History of the first attack is given, with a photograph, in No. 2, Vol. III., of the ARCHIVES OF DERMATOLOGY. That outbreak yielded to treatment about the first week of March, 1877; she had then, as can be seen, suffered from September, 1876, six months. She afterwards went to school, and was to all appearance healthy. During the treatment of that attack she used an unlimited quantity of cod liver oil, the internal administration of which I was occasionally forced to suspend on account of gastrointestinal disturbance; the same oil, and that of sweet almonds,

was used for inunction after baths. In this case I was forced at last, for economy's sake, to use oleum lini for inunction. She was wrapped in cloths soaked with it, and cure soon thereafter occurred. It was shortly after this that I used it on the case of pityriasis rubra mentioned above.

April 29, 1878. The child was again brought to me, suffering from febrile symptoms, and with an eruption on chest, bullous in character, but at that time bullæ so small as to be not much more than vesicles. She had been suffering from prodromata nearly a week. In the following few days the fever increased, and the eruption spread, becoming more distinctive and decided.

It is unnecessary to give the daily history, it being so typical a case, suffice it to say that if Hebrâ's summary of Cazenave's description of this malady be read, it will give word for word an exact description of the appearance and progress of the affection in all points except the "always fatal termination."

She took no medicines except a little elixir calisayæ, and a few drops of Fowler's solution, say ten minims in all, given in fractional doses at different times as a placebo ; but she was given, in conjunction with other foods, the ground linseed in milk, as before mentioned, and after a bath made slightly alkaline with bi-borate of soda, oleum lini was liberally applied and kept on day and night.

For the first ten or twelve days, owing as much to febrile anorexia as to disrelish for the food itself, she did not take kindly to her porridge, but thereafter eat freely of it, and improved "pari passu."

June 17. Patient came to my office entirely well, decidedly stouter, and feeling well in every respect ; able to go to school. The duration of the treatment to successful issue was, therefore, about six weeks. It may be remarked that the bullæ formed, as in the previous attack, upon the mucous membrane of the tongue and pharynx as well, and were characterized by the same sour-milky contents as in other parts of the body.

CASE NO. IV. *Pemphigus vulgaris* ; inveterate and persistent. Mrs. Mc., æt. 34 ; mother of three healthy children ; husband healthy. This case (as indeed all save No. II.) was shown at meeting of the New York Dermatological Society, and the history of this is briefly given in the Report of Proceedings, Feb. 26, 1878, ARCHIVES OF DERMATOLOGY, Vol. IV., No III., p. 234.

She had been scarcely ever free from eruption for three years, and most of the time was in a condition most repulsive to herself and others. At the time of exhibition to Society she had about two hundred patches of bullæ, and a number of fungating but superficial ulcerations. She was emaciated, and generally broken down.

She had been treated by several reputable and intelligent practitioners known to me, and had gone through the orthodox



pharmaceutical curriculum very thoroughly and continuously. The last treatment pursued previous to my being called in, was on the basis of the trouble being syphilitic in origin, and appropriate medication had been carried out with negative or evil results.

She came under my care the end of February of this year. At the end of May I discontinued my visits. She had in that period gained thirty-two pounds, having weighed only ninety pounds when first seen, and is, or was when seen a couple weeks since, a healthy, plump and cheerful woman, quite different from the invalid who, I think, had not been out of the house more than a couple of times in as many years before.

As to the medicinal treatment in this case, I am inclined to give it great credit for the success attained. My prescriptions were not much or often changed from the commencement, and consisted, in brief, of mild doses of strychninæ nitratis, quinia, liquor ferri nitratis, and acidum nitrohydrochlor. dil. This latter was given pretty continuously, and is even yet made use of when she feels at all languid or debilitated. Arsenic, in the form of Fowler's solution, was also given for two or three days at various times, but though the doses were mild, they were always followed by gastric and other symptoms, leading me quickly to discontinue it. Another remedy used was, I think, of great benefit in conquering the diathesis, namely, McKesson and Robbins' phosphorus and nux vomica pills, containing 1-60th grain of the former, three or four times a day. I shall certainly always in the future use this, or a similar compound, in this class of cases, both in view of what I consider the pathology of the disease and from the apparent decided benefit received in this case.

The chief reason why I have put this case on my list, however, is to show how rapidly flesh was gained, chiefly, as I believe, owing to the use of linseed and oil. She, as the others quoted, used it internally, externally, and almost eternally for the whole period of treatment. The various modes of administration were tried, and never, during the whole time, did she suffer from anorexia, diarrhœa, or eructations from its use, but on the contrary relished it thoroughly, and took several, certainly three or four, ounces daily as food.

The limits of time, and fear of taxing your patience, forbid my dwelling on the cases of ichthyosis (four in number) treated in this manner. They were all improved and relieved, one of them not so much as the others, owing to carelessness, together with obstinacy, on the part of the patient as well as of the disease. Much more than decided relief of symptoms is hardly to be expected in this extremely chronic disease. If my theory be correct as to the specific determination of this remedy to the sebaceous glands, it would seem rational treatment.

I have now in mind many cases of chronic eczema of hands, etc., which I have treated by external use of this oil, with cure

following in all cases save one, now under treatment. This latter is in the person of a janitress of one of our best dispensaries, who has been under the care of many most intelligent medical men at intervals for the past twelve years, with varying treatment, constitutional, local, or both, soothing, stimulant or alterative. She is enthusiastic over her present state, her hand having been for years entirely useless up to this time. The treatment in her case has been raw linseed oil, with one or two wrappings or bags of old linen. I have before tried in these cases perfectly imperious bandaging of rubber, both pure and composite, and do not like them *continuously used*, as they have always in my experience seemed to overstimulate the skin, and prevent a necessary transpiration. The comparative impermeability of this form of wrapping I find the best in such cases.

## NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.\*

BY L. DUNCAN BULKLEY, A. M., M. D.,

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**XXII. Phthiriasis.** The presence of lice is a far more frequent cause of irritation, and consequent lesion, of the skin than is commonly supposed, and must ever be borne in mind by the physician even when practicing "among the best families." As is well known, there are three varieties found, affecting severally the head, the body, and the pubis and axillæ: the treatment is, of course, entirely local, and differs somewhat according to the locality of the parasite; we will, therefore, speak separately of phthiriasis capitis, phthiriasis corporis, and phthiriasis pubis.

Among the poor my almost constant treatment for lice in the head is kerosene oil, which not only operates as a destructive agent to the insects, but acts very kindly upon the artificial eruption, which is sometimes observed in great severity among the lower classes, where the large part of the scalp is often found to be covered with exuding surfaces. My method of using the oil is as follows: The ordinary kerosene, which is found in every family for use in lamps, is poured on the head freely, and well rubbed in; this on the return home from the clinic. At bedtime another similar application is made, and in the morning, on rising, a third, the

\* These notes are intended to report, for the use of the general practitioner, the local measures in common use by the writer in the treatment of diseases of the skin. It is not intended that they shall be exhaustive, nor that these measures are recommended to the exclusion of constitutional treatment. The formulæ are not claimed as original, although some of them may be. These "Notes" are continued from pages 212 and 307 of Vol. II., pages 24, 127, and 314 of Vol. III., and pages 49 and 225 of Vol. IV.

head being kept in the meantime covered with a cloth. After the scalp has thus soaked in kerosene oil for twenty-four hours, it is thoroughly washed with soap and water, and a small amount of weak ammoniated mercury or oxide of zinc ointment is applied to any existing sores, or a subsequent anointing with cod-liver oil affords admirable results. This single application of the kerosene oil for twenty-four hours effectually destroys not only every louse, but penetrates the ova or "nits," and they will be found loosened from their attachments, and even if left on the hairs they will not hatch out. I never order the hair to be cut, even in the very worst cases; where the hairs are matted together with filth and exudation, the oil penetrates and softens all, and among hundreds of cases thus treated I have never seen it fail, whilst cheapness and safety, as compared with washes of bichloride of mercury, etc., especially recommend it.

The coverings for the head must also be treated or a new infection may take place; these I order to be placed in the oven of a range or stove, upon a board, and to be thoroughly baked for at least two hours.

Although the idea of applying the oil to the head of those in better classes of society may seem repulsive, I have employed this treatment in a number of cases in private practice and with the same results. The end is accomplished so surely and so quickly that patients submit to the disagreeable odor for the time (in them it may be counteracted afterwards by the essential oils, as bergamot, lavender, or rose, in washes or pomades,) while there is no other remedy with which I am acquainted which will with such certainty destroy the nits.

If the oil is objected to for its odor, or for other reasons, we have in the infusion of stavesacre, the seeds of the *Delphinium Staphisagria*, a cleanly and efficient remedy; but this requires a longer application, and, I believe, does not affect the nits, which must afterwards be patiently picked and combed out; the destruction of the nits is assisted materially by the frequent use of a wash of alcohol and aromatic vinegar or aromatic spirits of ammonia, in equal parts, diluted if necessary. When there are but few lice an ammoniated mercury ointment (gr. xx-xxx ad  $\mathfrak{z}$  i) will suffice, or of powdered stavesacre seeds ( $\mathfrak{z}$  i ad  $\mathfrak{z}$  iv); this latter will be much stronger if the ointment is melted and the powder added while hot.

Phthiriasis corporis, or lice on the body, may be speedily removed by absolute cleanliness and a proper treatment of the clothing. It is well known that the ova of this variety are deposited on the clothing; the undergarments, therefore, should be thoroughly boiled or baked, and clean ones, which have been thus treated, put on immediately after a bath. Among the poor I very commonly give a wash of carbolic acid and caustic potash after the following formula:  $\mathcal{R}$  Acidi carbolic,  $\mathfrak{z}$  ii, Potass. caustic.,  $\mathfrak{z}$  i, Aquæ,  $\mathfrak{z}$  iv, M, the potash to be dissolved in the water, and

to be added slowly to the carbolic acid, in a mortar, with friction. This is an admirable anti-pruritic, while at the same time the carbolic acid assists in driving off the insects. Where they can be employed, alkaline baths are of great service in relieving the pruritus which often remains even after the removal of the lice.

Phthiriasis pubis refers rather to the variety of the parasite than to the region occupied, for the same round, crab-like insect may be observed on the hairs of the pubis, chest, axillæ, eyelashes and eyebrows, and even in the beard. The condition often passes unrecognized for a length of time, and unless pretty carefully sought for the animals will not be seen: they are found, as is well known, firmly attached to the hairs at their very exit from the follicle, and present rather the appearance of a minute crust or scab than of a living creature. Occasionally their nits or ova are found on the hairs in abundance, but always very near their attached extremity.

Thus much is said in regard to the features of the disease because unless they are well borne in mind the parasite will not be reached. In vain is it simply to take baths and change and treat the underclothing, the crab-lice remains firmly attached, and is only gotten rid of by measures which reach it at its seat. The most common application is the ordinary mercurial ointment well rubbed in, but cases of salivation are continually occurring from this treatment, and other measures equally efficacious should be used. My usual remedy is the ointment of ammoniated mercury, either in full strength or once or twice diluted; if circumstances permit, kerosene thoroughly applied acts more speedily and surely than any other remedy: it should be well rubbed on with a cloth several times daily for one or two days. Stavesacre or sabadilla in powder or ointment, or a tincture or infusion of *cocculus indicus*, are common prescriptions for this state. Turpeth mineral, twenty to thirty grains to the ounce, is a safe and efficient parasiticide. Where the lice exist in many places sulphur vapor baths are of service, but do not reach the nits. Occasionally cases with the crab-lice will prove very rebellious, and can only be overcome by continuous treatment for some time; the reason of this is that the nits resist the destructive agents, the new lice are continually hatched out, again deposit their nits, and so keep up the infection.

XXIII. *Pityriasis*. Of the various states formerly called pityriasis but two retain the name in the acceptance of modern dermatology, pityriasis rubra of Hebra, known also as dermatitis exfoliativa, and pityriasis of the scalp; the pityriasis versicolor of older writers is now known as tinea versicolor, a parasitic disease, while most of the other forms of disease which were described as pityriasis are at present recognized to be but stages of other affections, principally of eczema. My remarks, therefore, will be confined to these two affections.

Little is to be said in regard to the local treatment of pityriasis rubra, which happily is very rare in this country. Warm alkaline

and starch baths, such as have been mentioned in previous articles, followed by continuous inunctions with such oils as cod-liver or almond, or the free use of cosmoline, comprise all that can be used with advantage. In the present issue of this Journal (page 303) Dr. Sherwell reports very well of linseed and linseed oil in this affection, which may be remembered with advantage in this connection.

Pityriasis of the scalp, an affection manifested by a dry, furfuraceous, epidermal scaling, with oftentimes epidermal masses extending on to the hairs, is quite distinct from seborrhœa, to which it bears some resemblance. Much is to be accomplished in this pityriasis by local measures, although, as a rule, it is intimately connected with and dependent upon general debility, which requires to be remedied if permanent effects are to be expected. The most satisfactory results which I have obtained in this dry "dandriff" of the scalp have been, I think, from the following prescription:  $\mathcal{R}$  Unguent. citrini,  $\mathfrak{z}$  ii, Tinct. cantharid.,  $\mathfrak{z}$  i, Unguent. aquæ rosæ,  $\mathfrak{z}$  ij, Olei rosæ, gtt ii. M. ft. unguent. This is to be well rubbed into the scalp, that is, into the roots of the hair, every night, not in a very great quantity, but with much patience. If the oiliness of the hair becomes intolerable or very annoying, the head may be washed with tar soap, or the sapo viridis of Hebra, or castile soap, or with equal quantities of borax and bi-carbonate of soda to an amount sufficient to make the water feel slippery, say one or two teaspoonfuls to a pint; *immediately* after the washing the ointment is to be thoroughly re-applied, before the skin is really dry.

For milder cases a quinine lotion suffices very well, such as a drachm or two to four ounces of spirit of rosemary, with about two scruples of borax and half an ounce of glycerine. A very common prescription of mine is as follows:  $\mathcal{R}$  Tinct. capsici,  $\mathfrak{z}$  vi; Tinct. cantharid,  $\mathfrak{z}$  iv, Olei ricini,  $\mathfrak{z}$  ij; Olei bergamot., gtt. xx; Alcohol ad  $\mathfrak{z}$  iv; M. ft. lotio: this to be well shaken and applied every night.

XXII. *Prurigo*. Happily true prurigo is very rare in this country, for under this name we include only that almost incurable disease composed of fleshy papules, with glandular enlargement, so graphically described by Hebra, and of which scattered cases are undoubtedly seen in every country. The prurigo of older writers has vanished from the recognition of modern dermatology as clearer light in regard to the true nature of skin diseases has appeared. Thus, the itching due to pediculi, formerly called prurigo pedicularis receives the name phthiriasis, while many other forms of itching are found to be symptomatic; the word *pruritus*, therefore has come to be used to designate itching, whether idiopathic, as *pruritus senilis*, *pruritus vulvæ*, *scroti*, etc., (which will be considered in the next section,) or symptomatic, as the *pruritus* of eczema, prurigo scabies, etc.

It would be hardly possible to give here more than an indication of the local measures of service in this distressing affection,

especially in view of its great rarity in this country. Suffice it to say that they consist of such measures as soften and remove the epidermis ; such as, prolonged baths, together with frictions of green soap or the repeated application of tar combined with baths, together with many of the remedies to be mentioned under pruritus.

XXIV. *Pruritus*. Far other is the prospect of relief in pruritus, and far more varied and also more serviceable are the measures employed. Pruritus or itching, meets us as an important element of very many skin diseases, and the measures directed against the latter generally accomplish much for the relief of the itching ; it is not intended here to enter exhaustively into the subject but only to give a few hints in regard to the general management of this state, often the cause of the greatest distress, which, as before mentioned, may exist as an element of other diseases, or may occur without any visible lesions on the skin, except those caused by the scratching, or by the remedies employed for the relief of the itching.

First, then, it is all important to be sure that no external and removable cause exists which may provoke or prolong the cutaneous irritation. Not infrequently the itching is owing to the presence of parasites, lice, fleas, bed-bugs, etc., and this often to the greatest surprise of the patient ; sometimes it is due to new underclothing, woolen or cotton ; sometimes to over-stimulation of the skin in baths, or with towels or flesh gloves, etc. Not infrequently what is complained of as simple pruritus or itching is found to be really an eruption of urticaria, eczema, or lichen, etc.

Eliminating, then, these cases, there undoubtedly present themselves a not small number of persons in whom itching appears to be and really is the only affection, and for the relief of which the advice of the medical man is often sought ; these cases cannot or must not be slighted, for the suffering in them is real and often intense. Sometimes the itching is general, sometimes local, in one case permanent, in another intermittent. Not infrequently itching will so disturb the patient's sleep that the general health and nutrition is impaired. It is useless to tell the sufferers not to scratch, the desire is often perfectly irresistible, nothing short of actual physical restraint can prevent the patient from rubbing, pinching, or scratching the skin, and indeed sometimes nothing else will give relief.

General pruritus, when not dependent upon local causes or a part of some other skin affection, will very constantly be found to be dependent upon functional derangement of the liver, (not necessarily accompanied by jaundice) and local measures are at the best only palliative, although, by the relief they give they may carry the patient through until the disordered organ is relieved by nature or art ; in some instances, in aged persons, the itching is a result of the general atrophy of the skin, pruritis senilis. Warm alkaline baths, as recommended in previous "Notes," for other

affections, will often give the greatest relief to such pruritus : the body should be anointed after them with some unctuous substance, as the glycerite of starch, or cosmoline, to which, if the itching is severe and persists, a drachm or two of tincture of camphor, or one or two drachms of oil of cade, may be added to each ounce. The lotion of carbolic acid and potash, as advised under phthiriasis, is also of the greatest service, and may be freely applied ; when used for pruritus it is better to replace a part of the water with glycerine, say half an ounce in the four ounce mixture.

When the pruritus resists these measures, tarry preparations may be used, and of these the *liquor picis alkalinus*, which I introduced some years ago, admits of the greatest variety of applications. The formula, which has been already given in these "Notes," is as follows :  $\mathcal{R}$  Picis liquidæ, 3 ii, Potass. causticæ, 3 i, Aquæ, 3 v, M. Dissolve the potash in the water and add slowly to the tar in a mortar, with friction. This may be diluted to any extent, and used as strong as is required : one part of the "liquor" in ten of water gives much relief to pruritus, but often it is necessary to use it several times this strength. The compound tincture of green soap of Hebra is a less efficient anti-pruritic, when there is no actual lesion of the skin, but sometimes it renders good service even in general pruritus.

(THE SUBJECT OF PRURITUS WILL BE CONTINUED.)

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## Clinical Reports.

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### I. *Clinical Conversation on Diseases of the Skin.*\* BY THE EDITOR.

*Reported by Robert Campbell, M. D., Clinical Assistant.*

CASE I. *Pseudo-pigmentary syphiloderm.* The case of this woman, Mary Smith, aged 27, who has a tubercular eruption of syphilis, is very interesting because there exists also on the sides of the neck a lesion or condition of the skin which *resembles*, in a certain degree, the *pigmentary syphilide* which has been described by Hardy and Fournier of Paris, but which is not, as a rule, accepted by or known to dermatologists; and in regard to the existence of which there has been some discussion of late.

Some of you may remember a case of true pigmentary syphilide on the neck of a young woman also aged 27, who was in attendance here last winter and spring. The appearance in her case was as follows: Both sides of the neck were covered, from the head down on to the chest with a dirty brownish discoloration, with scattered white patches upon it, looking as if the dark portion had been freshly painted, and the paint removed in spots with the end of the finger. The skin in these places was of a normal color, without the marble-like whiteness observed in leucoderma, and there was no increased pigmentation around their borders, as is seen in that affection.

Note well the conditions in the present case, which at first glance suggest those of the true pigmentary syphilide. This woman has, as you see, a brownish discoloration on both sides of the face, which extends down on the neck, even on to the shoulders; and here on the neck are a number of white spots, mostly oval in shape, of various sizes. But if you look more closely you will see that these spots are all very superficial cicatrices, many of them very delicate, and when we inquire we find that about two years ago she had a tubercular eruption in these locations, much the same as that now existing on the right cheek and elsewhere. Moreover, the coloration of the pigmented portion is much too dark, too brownish, to answer to the descrip-

\*Cases shown, and remarks made to private classes at the Demilt Dispensary.



tions of Hardy and Fournier; far darker and browner than in the case previously mentioned. Also the disposition and general appearance of it about the face is that of the ordinary chloasma, of which many examples are seen from time to time at this clinic.

This then is simply a case of chloasma, in which the pigment has been removed by a previous ulcerative tubercular syphilide. Such cases as this may have given rise to the suggestion of some that the pigmentary syphilide does not exist as an independent affection, but is always the result of a previous syphilitic eruption, leaving a pigmentation. Here we have a previous ulcerative lesion of syphilis *removing* the pigmentation of chloasma.

This woman's eruption is disappearing rapidly under the mixed treatment (℞. Hydrag. bi-chlor. gr. i.; ferri ammon. cit., ʒ ij.; potass. iodidi, ʒ iv.; tincturæ nucis vomic. ʒ ij.; tinct. cinchon. comp., ʒ iv.; M. ʒ i., after eating), and we will not alter the prescription. The staining on the neck is, of course, uninfluenced by it.

CASE II. *Erythematous eczema closely resembling tinea circinata and psoriasis, and remarkable for the symmetry of development of the lesions.* Every time this little patient has presented herself lately the eruption has so strongly suggested that of tinea circinata or ringworm of the body, that you have seen me examine the case carefully, and note the points of similarity and dissimilarity. The little girl, Annie C., 8 years old, first came under treatment five months ago for an eczema of ordinary form, which yielded well and quite promptly to the following treatment: ℞ Potass. acetatis, ʒ ss.; tinct. gent. co., ʒ j.; aquæ, ʒ iiij.; M. Teaspoonful after eating; ℞. Unguent. picis, ʒ ij.; unguent. zinci oxidi, ʒ vi.; M.

About a month ago she returned to the dispensary with a new development of the disease of a few days duration. The eruption this time has increased by the appearance of new spots, even while under treatment, and it is only lately that this tendency seems to be checked. Some of these spots on the neck have so much the appearance of tinea trichophytina corporis, that it would be well nigh impossible to make the diagnosis from them alone, except by excluding the parasitic disease by the absence of the fungus from the scales. These spots, you see, are round or oval in form, of a pinkish red, with well defined edges, and with a moderate amount of scaling, and moreover with some tendency to clearing up in the center.

But when we strip her and examine the whole eruption, we can feel certain that the disease is eczema, and not a tinea; and a very great help in deciding this is afforded by the very peculiarly symmetrical development of the eruption. Here at the inferior angle of each scapula, in precisely the same situation on either side, you see two oval spots with the same characters as those on the neck, about the size of two large almonds. Also in the hollow above the nates, on each side, is a more round patch of

the same. Crossing the arms, so as to bring the spots near together, we see one near the insertion of each deltoid, also others over the lower end of each triceps, and those on the forearms are also seen to be symmetrical. On the thighs we observe a like similarity of position and appearance of the eruption, also on the lower legs, and finally on the insides and soles of the feet. Each eyebrow is also occupied by a little patch of the eruption.

Another peculiar feature is that the spots always appear first on the left side, and you may now observe that all those on this side are greater than those on the right. The patches first alluded to on the neck are of recent occurrence. They are on the left side, and will probably soon be followed by others in a similar situation on the right, that is if the disease is not checked by treatment.

Now it might be said that it is almost an impossibility for ring-worm to develop thus symmetrically, in isolated spots far from each other. There is no objection, of course, to the parasitic eruption developing in any of the positions now occupied, but the chances are so infinitely small that a purely local affection should be thus situated, that it amounts to a certain negative.

Is not this eruption psoriasis? I think not, for many reasons: None of the scales, either on the new or old patches, have the white, silvery sheen belonging to those of this affection. On scraping the spots we do not come down upon the uniform, delicate membrane, which slips off in a mass, leaving a surface which a slight scratching will cause to bleed, as I have so repeatedly demonstrated here to be a feature of true psoriasis, and to be absent in other affections. The patches are none of them exactly circular; they are generally oval, and moreover they do not, as in psoriasis, first appear as small specks and enlarge, but seem to burst out at once, almost full size. Finally there are some patches which present more distinctly the features of erythematous eczema, with irregular, illy defined margins and little scaling.

Her general condition is not good. She is rather pale and nervous, and we will continue her on her ferro-arsenical mixture (*R. Sol. Fowleri*, 3 iss.; *ferri ammon. cit.*, 3 i.; *tinct. nucis vomic.*, 3 ii.; *tinct. cinch. comp.*, 3 iv.; *M.* Teaspoonful after meals), under which there is already some improvement; and also give her the same ointment, *R. Bismuthi sub-nitrat.* 3 i.; *unguent. picis*, 3 ij.; *unguent. simplic.*, 3 i.; *M.*

In regard to the cause of this peculiarly symmetrical development of the eruption, we must undoubtedly ascribe it to the influence of the nervous system, although by what means it acts to produce this effect we cannot even conjecture. It is to the sympathetic system, or perhaps what has been called the "trophic nerves," that we must look rather than to the ordinary spinal motor and sensory system, and a large, and as yet untrodden field of investigation is open in this direction for patient study and

observation. The nerve relations of certain diseases, as leucoderma or vitiligo, urticari., are certainly very striking.

CASE III. *Warts in a very unusual situation.* The condition seen on the end of the finger of this woman differs so much from anything that I have ever seen, that you will do well to observe it carefully. At first sight I felt almost certain that it was an epithelioma, but when observed closely it is seen to be only a number of verrucæ, closely grouped together. She is a sewing woman aged 33, and on this finger she wears a brass thimble, and the confined sweat, combined with some poisonous action of the brass have induced this local lesion in this unusual situation, and with this peculiar appearance; which may be thus described: On the end of the middle finger of the right hand is a mass of hard tissue, extending from a line from the edge of the nail down under its free border to a considerable depth, from one side to the other. The nail is tender, and she can use the thimble only with the greatest difficulty. The surface of the affected portion of skin is rough and uneven. There appears to be a little moisture beneath the nail. Looking at it very closely the surface is seen to be composed of a number of papillary prominences, and the entire structure to be a conglomerate mass of warts. She has also warts elsewhere on the hands.

We will direct first that she remove the irritating cause, namely, the brass thimble, and if she must sew that she shall use one of hard rubber. The warts are then to be touched with dilute acetic acid once or twice a day, and at night the finger is to be dipped into very hot water, and afterwards enveloped in the unguentum diachyli (of Hebra).

CASE IV. *Tinea trichophytina cruris* (eczema marginatum). This German, Louis K., aged 52, presents a skin lesion which it is important for you to know well, for it is not very uncommon, and if its true nature is unrecognized, the disease will prove exceedingly obstinate, whereas a proper appreciation of it will enable the physician to afford prompt and certain relief.

The patient is a tailor, and quite fat, two circumstances which promote the development of the disease, for his long sitting in a rather cramped position keep up the heat and moisture of the parts, whereby the parasitic growth is greatly assisted. On the inner side of each thigh, confined, as you see, to exactly the locations upon which the scrotum rests when sitting, is a surface of diseased skin, which is red, somewhat moist in places, with a few scales, and with a sharply defined margin externally, while internally the eruption extends almost to the crotch, it being, however, much less pronounced there than at its margin. The eruption itches very much.

The man has also on the body the scars of a bygone tubercular syphiloderm, and here, on the outer aspect of the left forearm, are the remains of one of more recent date, a group of purplish brown spots. In the first description of this eruption about

the thighs, under the title *eczema marginatum*, Hebra says that for a while he suspected it as being of syphilitic origin, and in this case, with these remains of a syphiloderm elsewhere, you might be pardoned for such a suspicion if you were not well acquainted with the lesions of syphilis and with this disease, *tinea trichophytina cruris*.

It is needless to tell you that this latter parasitic affection, due entirely to the growth of the fungus *trichophyton tonsurans* in the epithelial elements of the skin, has nothing at all to do with syphilis. It comes alike in those with and without this disease. Nor is it a form of eczema, nor amenable to the remedies of eczema. The sharply defined border, the healing towards the center, the absence of much moisture, etc., are all different from the features exhibited by eczema in this region.

Notwithstanding the acute phenomena exhibited at his first visit a week ago, I ordered him the following: R. Unguenti sulphuris; unguent. simplic., aa.  $\frac{3}{4}$  ss., M. to be well rubbed in at night, and to-day you see the surface much less red; there is far less moisture; the itching has diminished greatly, and the disease has made good progress towards recovery. Were the eruption simple eczema, it would have been rendered worse by this treatment. The benefit to the parasitic disease is due to the destructive effect of the sulphur on the vegetable growth. In private practice I generally use the sulphurous acid, as strong as can be obtained. He receives no internal treatment; the disease is local.

## II. *Suggestions on the treatment of intertrigo and rhus poisoning.*

By A. G. SMYTHE, Baldwin, Miss.

On page 245 in the July number of the ARCHIVES OF DERMATOLOGY for 1878, is a short article on the treatment of intertrigo of infancy, in which corrosive sublimate and the blackwash are recommended in this affection. For forty years I have used a decoction of the leaves or bark of the common elder, *sambucus Canadensis*, with as much success as could be hoped for in all sorts of chafing, either in infants, adults, or the aged, with no risks from the absorption of mercurials.

On the same page, in the same number, is an article on the treatment of rhus poisoning. I have had much to do with that affection, and for a number of years have used a saturated solution of the sulphite of soda, and so successfully that its popularity has become quite extensive, so much so that persons come from a distance beyond the bounds of my practice to procure treatment.

## Society Transactions.

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### AMERICAN DERMATOLOGICAL ASSOCIATION.

*Second Annual Meeting, held at the Grand Union Hotel, Saratoga, New York,  
August 27th-29th, 1878.\**

Present Drs. I. E. ATKINSON of Baltimore, L. A. DUHRING of Philadelphia, GEO. H. FOX of New York, C. HEITZMANN of New York, H. G. PIFFARD, of New York, S. SHERWELL of Brooklyn, R. W. TAYLOR of New York, A. VAN HARLINGEN of Philadelphia, E. WIGGLESWORTH of Boston, and JAMES C. WHITE of Boston.

The President, Dr. James C. White of Boston in the chair.

#### FIRST DAY. MORNING SESSION.

The Association meet at 9.30 A.M. ; and, after a business meeting with closed doors, the scientific proceedings were inaugurated with the following introductory remarks by the President, DR. WHITE :

GENTLEMEN ; It is my pleasant duty again to greet you and to announce that the second annual meeting of the Association is open. I have but little to add to what was said at the beginning of the session at Niagara a year ago with regard to the important purposes of the society. The time which has intervened has only confirmed me in the opinion then expressed. Systematic progress in dermatology in certain directions, where reform is most needed, moreover, can be accomplished only by concerted action, and this is the only working body in existence by which this may be undertaken. I need not again refer to the nature of these faults in our special department of medicine. Two standing committees were appointed, you will remember, at the last meeting, from which we may expect important aid in their correction ; one upon classification and nomenclature, the other upon statistics. The difficulties met with by each of them in the very beginning of their work shows the necessity of their creation. Members of the former, in registering the valuable results of their collecting, find themselves impeded for want of a satisfactory system under which they can be recorded ; while the latter, in discharge of their duty to prepare such, find hardly an accepted basis of agreement broad

\* Prepared from reports in the *New York Medical Journal*, *Boston Medical Journal*, *The Medical Record*, *Chicago Med. Jour. and Examiner*, and *Phil. Med. Times*.—ED.

enough to serve as a starting-point for their labors. There can be no doubt, however, that the results of their work, incomplete as they at present are, will commend themselves to the Association and insure their perpetuation.

Two other objects in the interests of Dermatology we should also constantly bear in mind: to secure proper instruction in our branch in the schools of medicine, and the establishment of fit hospital accomodation for the study and treatment of skin diseases.

It is pleasant to be able to refer to the advance of our specialty through the contributions of individual members of the Association during the past year. I have prepared a list of the articles published by them in addition to those presented as an appendix to the president's address at our last meeting, and, as you will see, it forms an extensive and valuable literature. A considerable proportion of it consists of the papers prepared for the Association, and demonstrates how satisfactorily one of its aims has been fulfilled.

During the past year we have lost one of our number by death, Dr. Durkee, of Boston, the oldest member of the society, and one of the earliest dermatologists of the country. A list of his works will be found in our last transactions.

It remains for me only to announce that the Association is ready for business in accordance with the programme before you.

The first paper read was by DR. ATKINSON, on

### **The pigmentary syphiloderm,**

His object, he said, was, first, to briefly review the characters of the pigmentary syphiloderm, and, second, to give some account of a number of cases of it which had occurred under his own observation. A lucid account of the affection had been given by Hardy, and his views had been fully supported by Fournier. According to the latter authority, this peculiar pigmentation was liable to occur at any time from the fourth month to the end of the second year of a case of syphilis. It occurred almost exclusively in females, and was usually found on the neck (about the lateral surface). It consisted of faintly-colored spots, varying from the size of a split-pea to that of a finger-nail. Interspersed among these there were spots of natural skin with a pigment border; so that sometimes a regular network was formed. The pigment-area was of a *café-au-lait* color, and, consequently, paler than tinea versicolor or cloasma uterinum. The spots are smooth, not raised above the surface, and without desquamation. There are no subjective symptoms. The affection was remarkably rebellious to treatment; not infrequently lasting for months, and even years.

The first case mentioned was that of a girl of seventeen, who, five months before she came under observation, had had sores on the vulva, followed by an eruption in the skin, as well as suppurating buboes. On a physical examination, mucous patches were

found, and on the thighs and abdomen the remains of a previous syphiloderm were seen. There was an adenopathy in the cervical region; and on the lateral surfaces of the neck and on the shoulder there were numerous spots of apparently abnormal whiteness from six to twelve millimetres in diameter. On more careful examination, however, it was found that these were, in reality, patches of natural skin, which were surrounded by areas of pigmentation. The tint of this discoloration was decidedly lighter than that seen in cloasma uterinum. There was no itching; but the patient was mortified by what seemed to her the dirty appearance of her neck. An appropriate course of mercurial treatment, both internal and external, was instituted, and the other syphilitic symptoms at once began to improve; but the maculæ did not disappear, although they gradually grew fainter in color.

Almost a year afterward she was seen, and it was found that the pigmentary syphiloderm had by this time disappeared. In the meanwhile she had married, and was then three months pregnant.

The second case was that of a female with a fair complexion, and nineteen years of age, who was first seen June 19, 1877. She had a vaginal discharge of three months' duration, a fading roseola, and a painless inguinal adenopathy. After seven months there appeared spots of discoloration on both sides of the neck, somewhat symmetrical in their grouping; but there was no network formed, as in the preceding case. By March the maculations had grown somewhat lighter in tint, but had not disappeared. In the meanwhile she had had an attack of iritis, and mercurial treatment had been kept up all the time. At present there are faint traces of the pigmentation still left.

The third case was a somewhat anomalous one, as it occurred in a light mulatto, and the pigmentation was not situated in the usual locality. On the inner surfaces of the hands and knees there were apparently light-colored patches, which looked very much like old scars from burns. At first it was thought that there was true leucoderma in the parts; but when a more careful inspection was made it was ascertained that they were only islets of natural skin inserted in areas of discoloration, the tint of which was almost black. Consequently they appeared whiter than normal. A well-marked network was thus formed, with a distinct border, and a general piebald effect was produced. The patient was suffering from the usual symptoms of constitutional syphilis.

Dr. Atkinson was of the opinion that the affection would probably be more frequently observed than it is at present (and even in males), if it were looked for with greater care. It was possible that it might be confounded with cloasma uterinum or cachecticum, or with the stains of roseola. *Tinea versicolor*, however, was always distinguishable on account of the presence of the parasite. The stains left after roseola more nearly resembled it than any other condition, but when these were present there was usu-

ally a clear history of preceding hyperæmia ; besides, they were of shorter duration.

He considered it unfortunate that Dr. G. H. Fox should have called the pigmentary syphiloderm vitiligo ; since, even though the inclosed spaces contained less coloring matter than normal, there were equal claims for more than the natural amount of pigment in the surrounding areas, to those for the loss of it within these. Besides, the leucodermatous condition was by no means always seen.

It was claimed by some that the discoloration was not syphilitic because it was not affected by mercury ; but it was well to remember in this connection that pigment readily disappears after an acute hyperæmia, but that after an old trouble, like chronic eczema, for example, it may last for years. Non-vascular pigmentation was proverbially obstinate.

Dr. HEITZMANN thought there was no reason to form a new class of syphilitic skin-disease. He had seen repeated cases of the maculate form of syphilis, in which there was, apparently, pigmentation from the very beginning. In such cases we might very readily overlook the hyperæmic stage.

Dr. DUHRING said that ten years ago he had seen two cases in Paris which Hardy had called pigmentary syphiloderm, but he thought that the discoloration was altogether too faint to render them satisfactory ones. Since then he had for years sought for a case in the extensive venereal wards of the Philadelphia Hospital, but had never seen a single one until within a few months past. The pigmentation in this patient corresponded exactly with admirable description given by Fournier, and he could not doubt that it was really a case of pigmentary syphiloderm. When he saw the patient there were no manifestations whatever of syphilis present, but there was a clear history of the disease previously. In three months there was no change whatever in the affection.

Dr. SHERWELL had recognised this kind of pigmentation, but could not connect it especially with syphilis. Within the last week, however, he had seen syphilitic infant in which there was a pigmentary deposit corresponding with the affection described in Dr. Atkinson's paper.

Dr. ATKINSON thought that it did not apply to children, and that the discoloration in this case was in all probability due to the child's cachetic condition.

Dr. Fox remarked that the points at issue could only be determined by dermatologists everywhere making careful observations and then comparing notes. He thought that, while syphilis undoubtedly sometimes caused the affection in question, an undeserved dignity had been conferred upon it by classifying it as a variety of syphilis, and that we had no right thus to make a distinct class of it. Pigmentary syphilis was probably to be regarded as a vitiligo, with staining by melanin, from deterioration of the pigmentary elements of the blood. Certainly vitiligo, as ordinarily defined,



corresponded exactly with the so-called pigmentary syphiloderm. It was a fact, however, he said, that all the cases of vitiligo which he had seen occurred in syphilitic subjects, although one of the patients, a young man, claimed that the mottling observed had existed from childhood, and consequently before his syphilitic trouble.

Dr. PIFFARD said that he had never been able to recognize it as a distinct syphilitic affection, and that we met with vitiligo corresponding with it both in syphilitic and non-syphilitic patients. Dr. Atkinson had spoken of vitiligo as being progressive and permanent; but he thought this statement needed modification. Sometimes there was a period in the disease when it became stationary; and, again, pigment sometimes returned spontaneously.

Dr. TAYLOR called attention to the fact that the affection had been principally noticed by French authors, and remarked that it was met with, for the most part, in the Latin races, who had tendency to pigmentary changes of the skin. He had himself observed it in a number of patients both syphilitic and non-syphilitic and had seen it both with and without the whitish patches. A point in favor of its not being specially of syphilitic origin was the fact that it occurs by preference in a region which is ordinarily notably free from syphilitic manifestations. His conclusion was that it was met with principally in individuals of dark complexion, having a tendency to the deposit of pigment (in the Latin races particularly), and that its connection with syphilis was only as a rather rare coincidence. It is certain that severe constitutional diseases did produce more or less extensive pigmentary deposits. He thought that Dr. Heitzmann's remark very apposite, that roseola was often followed very quickly by pigmentation, and mentioned a case in Charity Hospital, in which *café-au-lait* spots followed a delicate roseola within a week. In another case (the patient being an Austrian) white spots appeared in the exact location of a preceding roseola. In regard to the permanency of vitiligo, he knew of a physician who has vitiligo of the hands, which goes away in winter and returns in the summer. In winter his hands show no abnormality of color.

Dr. ATKINSON believed that the spots which are left after roseola ordinarily fade very rapidly, and thought it difficult to determine whether in true pigmentary syphiloderm there was a previous hyperæmia or not. In regard to the permanence of vitiligo, he said he had lately met with a case which made him think that it might be really less persistent than he had supposed. In particular spots the pigment returned; but still it was progressive, for other portions of the surface became leucodermatous.

Dr. DUHRING explained that the patient whose case he had described was a blonde, and that in her the affection could not be confounded with any variety of cloasma or vitiligo which he had ever seen before. It was certainly a very peculiar manifesta-

tion, and it corresponded most accurately with Fournier's description and differed entirely from chloasma and vitiligo.

Dr. ATKINSON remarked that Fournier was of the opinion that it occurred principally in blondes; upon which Dr. Taylor suggested that a French blonde had a very different complexion from what we are accustomed to designate under that term.

Dr. WHITE, after alluding to various causes of pigmentation in syphilis, stated that he had never seen any independent case of pigmentary syphiloderm. This, of course, was merely negative evidence; but the burden of proof certainly lay on those who claim this affection as a distinct syphiloderm. It was necessary for them to prove conclusively that it is to be found only in syphilitic cases, and that it does not follow hyperæmia, or occur as the result of cachexia.

Owing to the absence of Dr. BULKLEY, his paper on

**A new method of permanently removing superfluous hairs,**

was not read.\*

Dr. DUHRING then read the report of

**A case of the so-called xeroderma of Hebra,**

which was characterized by very extensive lesions, of a three fold character: these being pigmentation, telangiectasis, and atrophy.

The patient was a young woman 17 years old, of Irish parentage, father living, mother dead of cancer, several brothers and sisters alive and healthy, no family history of consumption. This child at the age of six months began to show upon her nose and cheeks freckles, which increased in number from year to year, and at the age of nine years were as extensive as at present. It was stated that three years ago, while employed at work with machinery, a dozen or more pinhead sized pimples came upon her cheeks, and when disappearing left pock-like marks. Dr. Duhring thought this latter an accidental eruption, and that the patient was probably mistaken as to their course. Within several years freckles had disappeared from the backs of the hands, leaving atrophy. Almost the whole general surface was pervaded with lentigines, telangiectases and spots of atrophy. The lentigines were scattered at haphazard, sometimes clumped. They were pinhead, but sometimes extended in almost a sheet. In color they were dirty yellow, brown, or almost black. Telangiectases were scattered about, but were most numerous upon the neck and chest; they were small and ill-defined, sometimes angular or rounded, and were generally of pinhead size. They were generally inconspicuous, seldom elevated. The skin could be readily picked up. The scalp was invaded. The atrophy upon face and back of hands was noticeable, but not very conspicuous. The patient's general health was good. There were

\* Published in full in this issue. See page 287.

no subjective symptoms. The points of interest were, the early age of the patient when the disease began (as is usual), the slow evolution and chronic course. The atrophy was very superficial. The pigment change was the first in the train of symptoms. The telangiectasis and freckles finally disappear, to be followed by atrophy.

From this case he was led to believe that the affection was not necessarily followed by such marked atrophy as Hebra, Kaposi and Taylor had claimed. This was the first case that had been met with in Philadelphia, so far as was known. He considered xeroderma a very inappropriate name for the disease, because it gives no idea of its prominent characteristics; and, besides, this term had been employed for years to denote a mild form of ichthyosis. The pathological process observed in the affection was very complex, involving hypertrophy and new growth, as well as atrophy. (A photograph of the case was exhibited.)

On motion of Dr. PIFFARD, the discussion of Dr. Duhring's case was postponed until after the reading of Dr. Taylor's paper on the same subject, and then Dr. Fox presented a paper on

### The proper use of the term Acne.\*

Dr. WIGGLESWORTH said that he also objected to the term *acne rosacea* (where there was nothing but dilated capillaries present), but he could not agree with Dr. Fox in holding that acne was to be distinguished from *comedo*. He believed that we had an acne (that is the same pathological condition) from plugging of the follicles or from the effect of bromine or iodine, as well as from indigestion, and that the word acne should be used in all these conditions.

Dr. VAN HARLINGEN thought it very desirable that we should be able to arrive at a satisfactory nomenclature for diseases of artificial origin. In regard to *comedo*, it was often present without acne, and *vice versa*.

Dr. SHERWELL said he made only the distinction acne and *acne rosacea*. He scarcely ever saw a case which could be described under any single distinctive term (there being usually more than one variety of the affection in the same patient); and he did not see any use in multiplying terms. He thought a distinction should be made, however, in regard to artificial acne.

Dr. PIFFARD said that, as to the etiology of acne, he could not go so far as Dr. Fox, but he did believe that the great majority of the cases were of internal origin. As to *acne rosacea*, the sebaceous glands were not involved at all in that affection, or, if they were, were only simply atrophied. When the glands were inflamed, we had acne *with* *rosacea*.

Dr. TAYLOR agreed with Dr. Piffard in his remarks on *acne rosacea*.

Dr. WHITE stated that many authorities claimed that acne fre-

\* Published in full in this issue. See page 300.

quently occurred in individuals who were in perfect health, to which Dr. Fox replied that he did not believe that they were in perfect health. If a thorough investigation were made in any such case, he thought it probable that some disorder of digestion would be found.

In the absence of Dr. F. P. FOSTER, of New York, the Secretary read a paper which he had prepared on

### **A case of scleroderma.**

He regarded it as specially worthy of record from its having been considered by several surgeons to be cancer, and from the fact that death took place without the recognized intercurrent of any other disease. The patient was sent to him by Dr. H. R. Hopkins, of Buffalo, and was an unmarried female of thirty-six, who had previously enjoyed good health, and in whose family there was no history of cancer. The affection commenced in a slight abrasion of the left nipple, which was followed by a small hard mass imbedded in the mammary gland. Later, the whole breast became more firm and less movable than normal, and infiltrations took place into the cellular tissue adjacent, which points, at first doughy, became more firm, with a tendency to involve the overlying skin. When first seen by Dr. Foster, the disease affected the whole of the skin of both breasts, that over the sternum and the whole left half of the chest in front (besides creeping around to the scapula behind), as well as the greater portion of the left arm and forearm. The proper substance of the left breast was very much shrunk, and the nipple was surrounded with a groove of ulceration. The most decidedly indurated portions of the skin were of a board-like hardness, and thinned, while the other indurated parts were somewhat swollen. The former were sharply defined; the latter, less definite in outline. Her general health was good, and all her functions were regularly performed. Dr. Foster prescribed tartrate of iron and potassium, and applied a mild galvanic current to the affected parts. A medical friend had suggested to her the use of *hydrocotyle Asiatica*, to which he made no objection. In a few days Dr. E. L. Keyes saw her in consultation, and concurred in the diagnosis of scleroderma. After a month she began to complain of a sense of constriction, and all the affected parts became more sensitive than before to the galvanic current. In a few weeks more she returned to Buffalo, and Dr. Hopkins continued the electrical treatment there. In a month after her return he noted an increase in the induration about both axillæ and also of the sense of constriction, combined with which there was now a decided shortness of breath. From that time there was a gradual progression of the disease, both in extent and degree, the induration, spreading over almost the entire trunk, as well as both arms. All the left breast became covered with highly-vascular granular tissue, and the patient suffered from almost constant pain in it, of a burning character. Later, she suffered terribly from dyspnoea

and an excruciating pain in the umbilical region, so that morphia had to be administered in large doses. So extreme was the suffering that it at length became necessary to give her no less than six grains of morphia every four hours, hypodermically, or thirty-six grains in the twenty-four hours. In fact, respiration seemed to be only possible at all when the system was under the influence of the narcotic. Afterward, however, the dose was reduced to twenty grains a day. Before death the induration of the skin extended in all directions, covering the abdomen, back, and, partially, the thighs, and extending upward to the hair behind and the jaw in front. It also seemed to get browner and firmer, until it was almost like sole-leather. No autopsy was made.

Dr. HEITZMANN remarked that, from the history, there could be no doubt that the case was one of lenticular cancer, and not scleroderma at all.

Dr. VAN HARLINGEN said that, in all the cases of scleroderma which he had seen or heard of, there had been no ulcerations, and the functions were not interfered with except from the tightness of the skin.

Dr. PIFFARD made some remarks in regard to the *hydrocotyle Asiatica*, which he said had been introduced by Boileau, and which had been used with more or less success in the treatment of leprosy, lupus, chronic eczema, and psoriasis. In one case of lupus he had employed it with marked beneficial effects, but was obliged to discontinue it on account of its producing epididymitis. There was another plant indigenous to this country, the *hydrocotyle Americana*, which was similar in its botanical characteristics, and he thought that it might also have the same medicinal properties. At all events, he intended to make a trial of it as soon as he had an opportunity.

Dr. TAYLOR said there were certain essential points in the history of the case which were wanting, and he thought it hardly fair to come to a positive decision in regard to it in Dr. Foster's absence. Perhaps Dr. Heitzmann thought it was cancer because there were ulcerations, but he did not believe that the ulcerations would invalidate the diagnosis, because he had seen a case of scleroderma in which there was such extensive ulceration as to render amputation necessary.

Dr. WHITE remarked that, at all events, it was certainly very unlike the ordinary cases of this affection.

#### FIRST DAY. AFTERNOON SESSION.

Dr. HEITZMANN read a paper on

#### **Epithelium and its performances.**

of which the following is an abstract :

If we watch a single living protoplasmic body (for instance, an amœba, a colorless blood corpuscle, or a pus-corpuscle) with high magnifying powers of the microscope (800-1,200), we invariably

will see a delicate network both within the nucleus and the protoplasm. The body is surrounded by an extremely thin, shining, homogeneous layer, and such a layer always lines vacuoles also, which temporarily or permanently may form in a creeping protoplasmic body. The network of the nucleus, its surrounding shell, the network of the protoplasm, and the covering and the lining shells, both of the body and its vacuoles, are formed by the living matter, the active contraction and passive extension of which cause all changes of shape and locomotion during the life of the protoplasm.

All formations in a highly-developed animal body (being analogous to the outer or covering layer of a single protoplasmic corpuscle, and therefore covering the outer surface and lining all cavities within the body, which are in direct or indirect connection with the outer surface) are termed *epithelia*. Formations, on the contrary, analogous to the wall of a closed vacuole of a single protoplasmic body bear the name of *endothelia*. Epithelia are present on the outer surface of the body, the skin, and its elongations, the hairs, nails, sebaceous, sudoriparous and mammary glands; on the cavity, termed the intestinal tract and its elongations (mucous and salivary, gastric and intestinal glands), and the liver; on the cavity of the respiratory tract and its mucous glands; and on the cavity of the genito-urinary tract, including all its elongations into the kidneys and the genital glands. Endothelia line the closed cavities of the skull and the spine, all its covering membranes, and all ventricles in the brain and their elongations into the spinal cord; the cavities of the chest, both pleural and pericardial; the cavity of the peritonæum; all articulations, and all blood and lymph vessels, including the cavities of the heart. A thorough distinction between epithelia and endothelia, however, cannot be maintained, as there is a direct communication between both on the openings of the uterine tubes into the peritoneal cavity; the epithelial formations of the ovaries are in no communication with the outer world, and the crystalline lens, a formation completely epithelial in nature, is covered by the endothelium of the anterior and posterior chambers. Epithelia and endothelia are fully identical in their intimate structure. There exist single epithelial layers in the body, for instance, those of the bile-ducts and the uriniferous tubules; and also ciliated endothelia, for instance, in the ventricles of the brain and the central canal of the spinal cord.

Epithelia and endothelia represent continuous layers of living matter. The former are the earliest formations in a developing body, after the stage of indifference (started by the segmentation of the ovum) is passed; they form the epiblast and the hypoblast. These are invariably devoid of blood-vessels and lymphatics, while all formations of the mesoblast, including its upper layer, from which arise the central nervous organs, are provided with blood-vessels and lymphatics. The epithelial and endothelial layers are built up by single, polyedral, protoplasmic bodies, the formerly so-

called "epithelial cells." Each body is separated from its neighbors by a narrow cloak of a lifeless, horny, cement substance, this being kindred to the basis substance in the connective tissue. Under the microscope we can see only the lateral parts of the cloak, which appear in the shape of a pale seam around each epithelium. The network of the living matter within the protoplasm of the epithelium sends delicate conical offshoots through all formations of the cement substance, both in epithelia and endothelia. These offshoots, up to the present time, have been termed "thorns of Max Schultze," in honor of their discoverer (1864). That the thorns are universal formations in the cement-substance, and especially formations of the living matter (thus building the bridge by which all epithelia are uninterruptedly connected), can be proved by different chemical reagents, and by the study of pathological occurrences within the cement-substance, viz., inflammation, fatty degeneration, etc. In the cement-substance run the finest terminating fibres of the nerves, also in connection with the thorns, and indirectly with the network in the interior of the protoplasm.

We distinguish mainly three varieties of epithelia: the flat, the cuboidal, and the columnar or cylindrical. Flat epithelia invariably construct the outer layers in stratified formations, cuboidal the middle layers, and columnar the lowest layer, nearest to the connective tissue. Single epithelial layers may exhibit any of the above-named shapes: in the uriniferous tubules, for instance, we find all the three varieties, according to the calibres of the tubules. Columnar epithelia have two sub-varieties, viz., ciliated epithelium, with whip-like elongations on the outer surface (therefore occurring only in single layers, the cilia being in connection with the network in the interior of the protoplasm—Th. Eimer and E. Klein), and the bacillated epithelium, where the outer surface of the cement-substance is provided with numerous delicate rods, such as are found in the intestinal canal and the bile-ducts.

All organs of the body termed glands are formations of the epithelium. We distinguish two varieties of glands, viz., the acinous and the tubular. A roundish elongation of the epithelium into the connective tissue forms a simple acinous gland, represented by the mucous glands of the oral cavity, the larynx, and the trachea. Repeated folding up of the pouch leads to formation of compound acinous, or racemose glands, represented by the sebaceous, the salivary, the lacteal, the prostatic, and other mucous glands. An elongation of the epithelium, prevailing in the longitudinal direction, is termed a simple tubular gland, represented by the gastric and the intestinal glands. Repeated ramifications of the tubules result in the formation of compound tubular glands, represented by the seminiferous and uriniferous tubules. Another sub-variety of compound tubular glands may originate by coiling of the tubule, as we see on the sweat and ceruminous glands.

The main performance of epithelium, besides the protection of the whole body, conduction of terminal nerve-fibres and, therefore,

of sensation, etc., is the elimination of used-up material from the body, viz., secretion. Every glandular formation is epithelial, and every epithelial body can be considered as a gland, inasmuch as the secretion is based upon a function of single epithelium.

There are mainly three varieties of secretion, viz., the watery, the mucous, and the fatty. The watery secretion cannot directly be studied under the microscope; we only conclude, by watching amœbæ stained with carmine particles, that, at any time when, through the visible contraction of the living matter within the protoplasm, carmine particles are thrown out from the amœbæ, a certain amount of its fluid is discharged also. A liquid, being present at one time in the blood, necessarily must pass through the walls of the blood-vessels and enter first the protoplasm of the epithelia before it can be expelled from these, evidently owing to the contraction of the living network of the protoplasm. The watery secretion is performed by the lachrymal and the sweat-glands; and the latter produce a fluid greatly varying in the amount of its solid contents and its consistence at different times. Near the approach of death the perspiration is inspissated and almost mucous in character, and the inspissation of the fluid pressed out from the blood-vessels of the tufts of the kidney is evidently the main performance of the uriniferous tubules.

The mucous secretion can be directly observed under the microscope: best on minute particles, cut off from the inner surface of a small intestine of a frog, by the addition of a very dilute solution of chromic acid or bichromate of potash, pure water being too rapid in its action. First we see swelling of the protoplasm near the outer or free surface of the epithelium. Here the covering cement-substance is bulging out; and, after having reached its utmost capacity of expansion, it bursts, and a pale, globular body springs forward—the swelled protoplasm, in which no trace of the former structure can be seen. A number of such pale globules coalesce, and form the jelly-like mass called mucus. At other times the whole protoplasm swells within the cloak of the cement-substance, and, after being freed, still shows the net-like structure of the protoplasm or isolated granules in lively motion, the broken particles of the former living matter. Salivary and mucous corpuscles arise from such slow action upon the protoplasm. The cloak of the cement-substance, partly or totally emptied and perforated at one end, gives the appearance of a “goblet cell.” A variety of the mucous secretion is that of the stomachic juice, of the bile, and of the semen; in the latter fluid there being suspended formations of living matter, the spermatozooids, a direct offspring of the epithelia of the testicles. Saliva represents an intermediate condition between watery and mucous secretion.

The third variety of secretion can best be studied under the microscope on colostrum corpuscles, which are suspended in the serous discharge of the mammary glands for a few days after delivery. Here we see the first-formed fat-granules still in connec-



tion with the network of the living matter within the protoplasm, and we readily arrive at the conclusion that fat is a directly transformed living matter. During the locomotion of a colostrum corpuscle, very often fat-granules are thrown up from its interior (S. Stricker). After a few days, however, no more colostrum corpuscles are secreted, because the living matter of the epithelia is completely transformed into fat-granules, leading to a destruction of the epithelia, the granules of which commingle with a serous fluid, and form the emulsion called milk. This process of fatty change of the living matter of the epithelia of the mammary glands is a remarkably rapid one. In microscopic specimens of the breast in full lactation, we find but little protoplasm unchanged, the greater part of it being transformed into fat-granules, which, having been extracted from the specimen with oil of cloves, leave only the shells of the cement-substance behind. The highest degree of fatty change of the protoplasm is reached in the sebaceous and the ceruminous glands.

Dr. Heitzmann's paper was discussed by Drs. ATKINSON, PIFFARD, and FOX. The latter said it was histological, rather than dermatological in character, and that he did not believe it possible to base the science of dermatology to any great extent on microscopical investigation. Clinical study, he thought, was more essential; and, for himself personally, it was of more advantage to pay less attention to the microscope, and devote more time to practical work. It was desirable, however, for some men who were peculiarly fitted for such studies to give themselves up to this kind of investigation, and he certainly thought that they were deserving of all praise for doing so.

Dr. PIFFARD also said that to consider microscopic study the only safe basis for dermatology was altogether too narrow a view, and that it should not be forgotten that we were physicians, as well as dermatologists. It was of more importance to study therapeutics, since our great aim was to cure disease. In our present state of knowledge, diagnosis by means of the microscope was undoubtedly a very uncertain matter, but at the same time, with Dr. Fox, he felt grateful to Dr. Heitzmann and men like him for their self-sacrificing efforts in the cause of science.

In closing the discussion, Dr. HEITZMANN remarked that the microscope did not lie, but its revelations might be misinterpreted. There were many things in connection with our science which were now puzzles, but which would be cleared up in the course of a few years, if the great field open to us were thoroughly investigated; and he could not but believe that scientific dermatology must finally depend on microscopical anatomy.

The afternoon's session was brought to a close by the reading of the report of the Committee on Statistics by the president, Dr. White.

## SECOND DAY. MORNING SESSION.

WEDNESDAY, AUGUST 28th.

At the business meeting at 9.30 A. M., the following officers were elected for the ensuing year :

*President*, L. A. DUHRING, of Philadelphia ; *Vice-Presidents*, J. N. HYDE, of Chicago, S. SHERWELL, of Brooklyn : *Secretary*, R. W. TAYLOR, of New York ; *Treasurer*, I. E. ATKINSON, of Baltimore.

The following gentlemen were elected active members of the Association : DRs. E. B. BRONSON, of New York ; F. B. GREENOUGH, of Boston, and G. H. ROHÉ, of Baltimore.

The first paper of the day was read by Dr. DUHRING, on a case of

**Inflammatory fungoid neoplasm.**

The first affection of the skin from which the patient (a married lady of fifty-eight) ever suffered was an acute attack of what seemed to have been vesicular eczema, in August, 1876. This was followed by repeated attacks of urticaria, showing excessive irritability of the skin ; and in October of the same year the first manifestation of the present disease made its appearance. This was a red spot on the right side of the forehead, of the size of a dime, not inflammatory, and looking like a superficial burn.

It gradually increased in size, and in August, 1877, began to rise slowly above the level of the skin, when it assumed a purplish hue, and presented the appearance of a boil. There ~~was~~ no subjective symptoms. Later, a number of tumors, of various character and sizes, appeared on the forehead, scalp and face, and also upon the trunk and extremities, most of them coming very suddenly, and some of them disappearing almost as rapidly. Later, some of them gave rise to considerable pain, and also to intense itching. In one day nine new, small tumors came upon the scalp, they were like gristle to the touch, freely movable, and soon disappeared ; also there appeared, without her knowing when, tumors upon her buttocks and back.

Dr. Duhring saw her first October 25th, 1877. The previous history, as given by patient, Dr. D. thinks reliable, she being a remarkably intelligent woman. When seen by Dr. D. the lesion involving the right side of the forehead (the original lesion), was of size of a half cherry, of a raspberry color, tense, containing no pus, tuberculated and furrowed. Inside of right arm was an oval papule, dull red in color. The natural lines of the skin were exaggerated. There was another tumor in the posterior fold of right axilla. Several patches were upon the abdomen. There was a patch in the groin half an inch in height, shape of a hen's egg, and smooth. There was much dusty yellow pigmentation. On October 26th Dr. Duhring observed a new lesion that had appeared since the night before. It was near the nipple, olive shaped, rough, of a deep pinkish color, soft and supple—not in-

flammatory, not changing color on pressure. It was evident that while tumors were continually appearing, they were almost as rapidly disappearing. Some were persistent, as those upon forehead. Some lesions grew with great rapidity. The growths extended over forehead, eyebrow, and scalp, both flat and tuberculated. Some of the patches disappeared as rapidly as urticaria. One tumor upon the left cheek softened and suppurated. This tumor after it had existed three months, was excised. Its cut surface was grayish yellow, and firm, like sarcoma. Its weight was one ounce.

Under the microscope (300), specimens of integument from them presented the following characters: The whole of the corium was infiltrated with a new growth, the cells being more abundant in its deeper portions. The walls of the hair-follicles were also packed with neoplasm. The cells were homogeneous in character, not being nucleated, as a rule. Some of them, however, had nuclei, but none more than one nucleus. There were no spindle-cells, as far as could be seen; nor was there any connective tissue or elastic-fibre bundles, as in normal skin.

New developments continued to manifest themselves from time to time, and on July 2d, 1878, Dr. Duhring strangulated a large tumor on the left cheek with a ligature. On July 4th ablation was performed, and this was followed by severe hæmorrhage; but the operation finally resulted in the most successful manner. This tumor was presented to the association, and although it had been kept in alcohol, it was still of the size of a very large horse-chestnut. It weighed one ounce when first removed. Before this time the internal administration of iodide of sodium, and later of arsenic, had been tried; but instead of being of any service, they both seemed to greatly aggravate the disease.

Dr. Duhring regarded the affection not only as new, but of such a grave character as to make it deserving of the closest study. Its course seemed entirely at variance with the ordinary manifestations of disease, and the fact that the general health remained unimpaired seemed to indicate that it was confined exclusively to the integument. There were two principal lesions—the flat patches and the round, tumor-like growths. The former were of various sizes, slightly elevated, dry, scaly, chapped-looking and furrowed, and were followed by dirty, yellow pigmentation. The tumors varied in size from that of a split-pea to that of an egg, some being soft and others firm to the touch. They were either smooth and tense, or else had an excoriated surface, from which oozed serous and bloody fluid, and they were distinctly furrowed or lobulated. The subjective symptoms were principally itching, with occasional pain and a burning sensation. One of the most remarkable features of the disease was the exceedingly rapid development, and sometimes equally rapid disappearance, of the lesions noted. When the tumors underwent involution, pigmentation was usually left, but no permanent scars. Hebra first met

with a case of this affection in 1872. He described it as new, and simply called it *neoplasma*. He met with a second case in 1874, which had been described by Hans Hebra and Geber; and these Dr. Duhring believed were the only two cases on record. During the course of the reading of the paper Dr. Duhring presented microscopical specimens from his case, as well as photographs and paintings representing its gross appearances; and at its conclusion exhibited the patient herself, whom he had induced to come on from Philadelphia.

The patient pointed out several large tumors upon different portions of the body, which had appeared in the few weeks interval of Dr. Duhring's absence from Philadelphia. Some of these were quite as large as pigeon's eggs, and were already undergoing involution, the process beginning in the center. A remarkable feature was the perfectly normal condition of the skin at the points where tumors had been, but had disappeared. There was not the slightest evidence of interstitial absorption.

DR. PIFFARD stated that he had seen two cases which bore some resemblance to Dr. Duhring's. The first was one which Dr. Sherwell had presented to the New York Dermatological Society, and in which the same kind of tumors were seen upon the forehead. The second was one of his own, in which the growths made their appearance different'y, but seemed to be of the same nature. The initial lesion resembled psoriasis, except that it was of a livid purple color. There were tumors on the thigh and calf also. After a time a change manifested itself in the interior of the tumors, the tops becoming flattened and the central portions sloughing out. Absorption of the periphery took place, and there was left a cicatrix, with pigmentation. In this respect the tumors differed from those in Dr. Duhring's case. The patient was brought before the New York Dermatological Society, in order that a diagnosis might be made; but no one ventured to give the affection a name.

DR. FOX remarked that he did not think Dr. Sherwell's case so much like Dr. Duhring's as Dr. Piffard's. He hoped that the latter would be investigated still further, as the patient was still residing in New York. It seemed to him that the disease was essentially the same in the two cases, and he had particularly noticed that one tumor on the neck in Dr. Duhring's case had a marked central depression, which was a prominent characteristic of most of the tumors in Dr. Piffard's. The fungating masses were also present. He remembered seeing in the St. Louis, at Paris, a case in which there was a single tumor (of similar character) springing from the thigh, and he thought it must probably have been a mild form of the affection.

DR. SHERWELL said that the case which had been spoken of in connection with his name had occurred four years ago, and that at that time he was inclined to think it one of tubercular leprosy. The chief growth occupied the superciliary region, and pressed

down upon the lid to such an extent that the eye could not be opened. The patient, who was an old man, passed from under observation before any careful study of his case could be made, and shortly afterward died. The cause of death was unknown to him, and he had not been able to get an autopsy.

DR. WIGGLESWORTH inquired if there had been any microscopical examination made in Dr. Piffard's case, and Dr. Piffard replied that there had not.

DR. DUHRING remarked that the inflammatory nature of his case seemed to be shown by the fact that the disease was greatly aggravated by iodide of sodium and by arsenic. He found that in skipping certain portions of his paper, on account of its length, he had omitted one very important part of the treatment, and this was that since the first of June the patient had been taking the tincture of ergot almost constantly. Its use, he believed, had been attended with very decided improvement in the disease. In regard to the removal of the tumor on the cheek, he said that he at first felt very much in doubt as to what would be the result of the operation, and that it had proved much more successful than he had dared to anticipate. During his absence from the city this summer Dr. Van Harlingen had also removed one of the large tumors on the thigh, and with equally good results.

The Secretary (in the absence of the writer) then read a paper by DR. W. A. HARDAWAY, of St. Louis, on

### **The treatment of hirsuties.**

Dr. Michel, an ophthalmologist of St. Louis, had for some time successfully employed electrolysis for the removal of "wild hairs" from the eyelids, and this had induced Dr. Hardaway to make use of the same method in dermatological practice. The method employed was as follows: The patient should be seated in a reclining chair, and facing a good light. The needle-holder is then attached to the negative pole of the battery, and an ordinary electrode, covered with a moistened sponge, is connected with the positive pole. Under a lens of about two inches focus, the needle is inserted the requisite depth into the follicle; the circuit is then completed by the patient pressing the sponge-electrode (anode) against the palm of the hand. The electrolytic action is allowed to go on until the peculiar white frothing is seen to well up around the insertion of the needle, when the current is at once interrupted by the patient releasing the positive electrode; after which the needle is withdrawn. Occasionally the hair comes away adhering to the needle; but generally it is necessary to remove it with a pair of epilation forceps. No force, however, should be used in extraction, for if the hair does not come away readily, it is an evidence that the operation has failed, and it should then be repeated. Dr. Hardaway went on to say that the smaller the battery the longer would be the time consumed; but if a large battery were employed, the pain would be proportionately in-

creased. With a good battery of eight elements, the desired result could be accomplished in from two to five seconds, and with a trifling amount of pain. Dr. A. E. Prince, of Jacksonville, Illinois, had used this method with very great success, and had invented a very ingenious and useful needle-holder for the operation. He preferred to use from five to ten cells of the Hill battery, which was a compromise between pain and speed. Dr. Hardaway referred to the works of Neumann and Piffard, in one of which the galvano-cautery, and in the other electrolysis, is recommended in hairy nævi; and then stated that Michel was the first to urge and systematize this method for the removal of superfluous hairs, and had taught the operation in his ophthalmic clinic for at least four years before its publication. Where electrolysis was not practicable, Dr. Hardaway used successfully a single drop of a solution of chloride of zinc (of the strength of two drachms to three drachms of water) injected into the hair follicle by means of a hypodermic syringe.

Dr. PIFFARD, in commencing his remarks on the paper, said that he had employed electrolysis for the purpose mentioned as early as Dr. Michel; but the latter certainly had the priority in publication. He did not see how these gentlemen were able to get the needle into the follicle while the hair was still there, on account of its minuteness. At first, he said, he had employed his own method only in the case of hairy nævi, but now he was in the habit of applying it whenever superfluous hairs were to be removed, provided they were not too small. He thought a steel needle might rust, and so had made use of a platinum one, adding a sufficient quantity of iridium to it to give it necessary stiffness. He was very much pleased with Dr. Prince's ingenious needle-holder, and had no doubt it would greatly facilitate the use of electrolysis. He did not think it was practicable to get into the very small follicles, and indeed it was only necessary to get sufficiently near the follicle, in order to accomplish the work of destruction. This, he thought, would account in great measure for the success which Dr. Hardaway met with. He denied that Neumann ever got into the follicle at all in his galvano-cautery operation, for it would certainly be most extraordinary if two wires could be introduced, without touching each other (as was essential to the process), into so small a cavity as that of a hair follicle. In Neumann's operation there must necessarily be a great deal of burning of tissue, and this would leave an unsightly scar. When electrolysis was employed, however, very little, if any, scar remained. He considered Hill's battery probably the best for the purpose, for although the current obtained from it was moderate, it was of great steadiness, and no sparks were produced by it, a matter of some importance in working about the head. He was not accustomed to wait for bubbles of hydrogen, but discontinued the current as soon as the white line appeared

around the follicle. On the whole, he thought the operation a very successful one after a little practice with it.

Dr. Fox thought the statement in the paper, that the pain was slight, was liable to mislead. Certainly, when a large number of hairs were to be removed, the operation was anything but a painless one, even with the use of all possible precautions. In some instances the follicles were destroyed, and in others not; and if latter was the case, the hairs would return. He thought, therefore, that it was desirable to use as small a needle as could be inserted to the bottom of the follicle. The irido-platinum needle of Piffard was preferable to a cambric needle (employed by Dr. Prince), as it could be drawn out more finely. Personally, however, he was in favor of using platinum-wire only, as it did not double up, as had been apprehended by Dr. Piffard, and passed into a follicle very much as a bougie passed into the bladder. He used only from four to six cells, on account of the less pain occasioned by a weak current, and followed Piffard in extracting the hair before applying electrolysis. A bright light was necessary in order that the patulous orifices of the follicles might be seen, and this was often very trying to the eyes of the operator, especially if the *séance* was a long one.

Dr. TAYLOR said that he had been using electrolysis for three or four years, and he employed a very delicate irido-platinum needle for this purpose. He considered the matter of pain quite an important element; and, in consequence of this, several *séances* were ordinarily necessary. He had had good results from this method in the treatment of comedones.

Dr. WHITE inquired if the effect was permanent, and in reply—

Dr. Fox said that no case should be reported until after a considerable time had elapsed. In one case he had removed as many as five hundred hairs, and, although the result was not perfectly successful, it was fairly encouraging. Sometimes hairs would return three months after removal.

Dr. WHITE then inquired if any gentleman present had succeeded in permanently removing fifty per cent. of hairs?

Dr. PIFFARD replied that in his experience, if the hairs were moderately large, about seventy-five per cent. would never return. The radical cure depended on the destruction of the papilla, and sometimes imperfect hairs would afterward make their appearance if the destruction were incomplete. It was impossible to get any satisfactory results whatever if the hairs were very minute.

Dr. TAYLOR stated that in his earlier cases he failed in permanently removing about half the hairs, but now he could generally destroy almost all of them.

Dr. WHITE said that he had tried the chloride of zinc in two cases, and his success with it had not been such as to warrant him in resorting to it again. He found that it caused great irritation of the skin.

Dr. HEITZMANN thought that it was better to postpone any

definite opinion on the subject of epilation for the present. He used to think that he got excellent results; but, after a longer or shorter period, the hairs almost always returned. He had used a nickel-plated pin dipped in strong nitric acid, sometimes pulling out the hair first and sometimes leaving it *in situ*. From his past experience he confessed that his faith in electrolysis was not at all sanguine; but he at all events thought it worthy of trial.

Dr. TAYLOR replied that he did not think Dr. Heitzmann's method comparable to electrolysis. He doubted very much whether any of the nitric acid at all got to the bottom of the follicle, while in electrolysis the destructive agent was applied just where it was desired.

Dr. DUHRING remarked that he had recently been experimenting in about half a dozen cases with a three-sided needle, and with fairly successful results. He introduced the needle directly into the follicle, and then gave it three or four turns, until a small drop of blood made its appearance. In order to succeed with this method it was necessary that the hair should be of pretty good size, and that both the papilla and the walls of the follicle should be destroyed. It had been suggested to him by Dr. Bulkley.

In answer to a question by Dr. Fox, Dr. DUHRING stated that the operation was unaccompanied by pain.

#### SECOND DAY. AFTERNOON SESSION.

DR. PIFFARD read a report of

#### **A case of gangrænopsis.**

A syphilitic child, one year old, with ulceration of the tongue and lips, snuffles, coppery plaques and tubercles over the vulva, buttocks, and thighs, was treated by mercury at Charity Hospital; the mother of the child was also suffering from constitutional syphilis. A nodule appeared near the left ala nasi, and in twenty-four hours it broke down and became gangrenous, the gangrene spreading rapidly, in spite of treatment, until nearly the whole of the face was involved by the time death occurred, ten days after the commencement of the trouble. A hypodermic injection of quinine was administered, and the point of insertion became a center of gangrene. (Photograph of case exhibited.) There was necrosis of the malar and other bones, partial pneumonia, with some centers of gangrene in the lung, and the blood was like cherry juice.

In regard to the etiology, he thought that it was either a malignant pustule or mercurial gangrene; more probably the latter. It was remarkable, however, that mercurial inunction had been practised on the child only two days when the gangrenous lesion began to develop.

Dr. DUHRING said he would hesitate before attributing this pathological process to the small amount of mercury employed,



and would prefer to consider it probably of internal origin and obscure. Dr. Taylor also thought these cases were of idiopathic origin, as a rule.

DR. HEITZMAN remarked that most of these cases which he had seen occurred in connection with, or as a sequel to scarlet fever.

DR. SHERWELL mentioned that within the past ten days he had known of two cases of gangrene of the mouth, one of which was of scarlatinal origin, while the other occurred in a strumous child without assignable cause.

DRS. HEITZMANN, DUHRING and others regarded the case as noma (cancrum oris) and disagreed with the writer as to the possibility of such symptoms being ever due to mercury.

DR. SHERWELL read the next paper, upon

### **The use of linseed and oil as therapeutic agents in diseases of the skin.\***

DR. PIFFARD understood that linseed bread could be made so as to contain no starch, and might, therefore, be used in diabetes. The oil contains no iodine and may therefore be more fattening. The seed makes a lighter bread than fine white flour, since it is so oily that it contains its own "shortening."

DR. ATKINSON then read upon

### **The botanical relations of the trichophyton (tonsurans.)**

Previous investigations into the botanical relations of the microscopic vegetations giving rise to certain skin diseases, have been fallacious on account of the faulty method employed. Cultivation upon sliced vegetables, as carrots, apples, etc., so inevitably become overwhelmed by adventitious growths as to make a definite conclusion from them impossible. But little less objectionable are the slide and mass cultures employed by recent mycologists, since there must necessarily occur far too frequent exposures in the repeated uncovering of the objects for investigation, etc. A method guaranteeing absolute purity to the cultivation is that employed by Van Tieghem and L. Monnier, in their researches into the mucorini. This plan is as follows :

A glass ring, four or five millimetres in height, with an interior diameter of about fifteen millimetres, is fastened to a glass slide by means of Canada balsam ; the spore to be cultivated is then sown in an appropriate nutritive fluid upon a very thin cover glass, the diameter of which is equal to that of the glass ring. The cell is then completed by laying the cover glass, with the nutrient drop underneath, upon the glass ring ; a few minute drops of oil upon the surface of the latter, upon which the cover-glass rests, serve to protect the cell from external influences. All fluids and appliances must be as pure as it is possible to make them. This method may be called the "cell-culture." In a cell like this a very small portion of hair-shaft, drawn from the follicle, is sown ; the nutri-

\* Published in full in this issue, see page 303.

tive fluid being either orange juice, Pasteur's fluid with or without sugar, decoction of horse-dung, or any other approved fluid, the first two being preferable.

In a large majority of cells thus planted there will be no change ; some will develop bacteria or molds of adventitious nature. In a few cells a mode of development will take place which is characteristic of the fungus of trichophyton, and can be readily distinguished from foreign fungus, the latter either thrusting its hyphæ under the cover-glass, or developing within the cell from a single centre and being readily discoverable, the mass of trichophyton cells remaining entirely quiescent.

Where, however, the cultivation is a succesful one, there is a simultaneous, uniform, multitudinous growth of hyphæ, accompanied sometimes by a decided swelling of the spores, which may become of many times their original size (figures shown) ; the latter, however, soon ceases as the growth of hyphæ becomes more vigorous. This activity begins to show itself at the end of from 24 to 36 hours, even later, and is completed in about ten days. Where the nutriment has been abundantly supplied, the tendency of the hyphæ is to form a dense mycelium and but few reproductive organs. In cases where the nutriment soon becomes exhausted, these organs appear more speedily, either with or without the development of septa in their hyphæ.

These reproductive organs are sporangial in character and occur in the case of the mucors. They do not often, however, produce perfect sporangia, the columellæ being frequently absent, or flat instead of conical, and the formation of spores being very limited. It is well known that under certain unfavorable influences mucor may be arrested or deformed in its growth.

Another kind of growth is an indication but not a completion of the broad cell formation of certain forms of mucor, consisting in a centripetal segmentation of the hyphal ends. Under more favorable influences these segments probably become separated, which condition occurs almost certainly in the growth in the hairs upon a patch of tinea tonsurans. The fungus unquestionably belongs to the mucors, probably to the mucor mucedo.

That in the very much larger proportion of cells, the sowing can be effected so as to secure an absolute freedom from other spores, is proved by the fact that in those cells the spores of which did not germinate it was the rarest occurrence to observe any other growth. Bacteria most frequently occurred ; penicillium very rarely, in a manner widely different from that of the trichophyton, and always from one or two centres, whereas the latter invariably showed a medusa-like growth of a multitude of the spores, which could be traced even from the first signs of vital activity.

In no case of successful cultivation was any other result obtained than the one shown and reported. The difficulty with which the spores germinated, made the sowing of small portion of hair shaft preferable to the planting of a single spore, since the chance of selecting a viable one was infinitely small, and the

characteristic, uniform mode of growth was regarded as most positive evidence.

These results were also obtained in "slide cultures," but were recognizable in the mass of adventitious growth only through the knowledge gained in cell cultivation. The method is one easily practiced, and requires only care, attention, and perseverance in spite of many disappointments, arising from the tendency of the spores to remain quiescent.

DR. VAN HARLINGEN read a very elaborate report of

### **A case of ulcerative scrofuloderm.**

It occurred in a female patient in advanced life, and was of long standing. When the patient came under the notice Dr. Van Harlingen, the entire surface of the body was affected, the color for the most part being browish red, except on the legs, where it was of an ashen gray. At many points there were deep, profusely suppurating ulcers, and about the right elbow was a singular group of hard, gray nodules. Almost everywhere else the skin was covered with fine scales, and in some places there were dead white patches, which were found to be cicatrices of former ulcerations. The ulcerations continued to increase in number and severity, in spite of all treatment, and the patient finally died of exhaustion. From the family history and condition of some of the internal organs, as shown at the autopsy, he was inclined to believe that the disease was of scrofulous origin. Under the microscope the horny and mucous layers of the skin seemed normal in character, but the papillary layers of corium-cells were markedly infiltrated. The upper and middle layers were principally affected, and the lower ones, to a much less extent. (Microscopic specimens presented.)

THIRD DAY. MORNING SESSION.

THURSDAY, AUGUST 29.

In consequence of pressure for time, a paper by the President, Dr. White, describing "a case of recurrent cutaneous hemorrhage, with urticarial and bullous efflorescence," was read only by title.

DR. TAYLOR then offered

### **A further contribution to the study of the xeroderma of Hebra,**

based upon cases described at the last annual meeting.\* The name xerodema is a bad one, and often confounded with xerosis; the name proposed by the committee on nomenclature is Dr. Taylor's title.

### **Angioma pigmentosum et atrophicum.**

There is first an erythematous or vascular condition in small reddish spots, which become pigmented later, though some may be brown from the first. In the red spots of longest duration the atrophic changes take place. Within an area of three centimetres

\* Archives of Dermatology, Vol. IV, No. 1, p. 66.

red spots will come and go, brown ones will come and go, and where brown ones were red ones will appear in time. Thus arise the atrophic changes, there being at first a proliferation of new cells, and a deposition of pigment, and then degeneration with absorption and cicatricial formation. Where the atrophy is marked there is no further deposition of pigment, and even previous coloration disappears, the calibre of the blood-vessels being obliterated by compression. Vascular regions subject to tension, such as the cheeks over the malar bones, the forehead, etc., are the parts most commonly affected. Of the portion attacked, only about one-fiftieth atrophies, giving the "parchment skin;" showing xeroderma to be an inappropriate designation. In some cases there occur upon the face tumors composed of blood-vessels and inflammation cells. These have been regarded as epitheliomatous, but may be only inflammatory growths. The disease may end in early life without harm, except pigmentation, which seems to endure indefinitely and may even make the patient hideous.

DR. HEITZMANN, who had seen these cases, thought that the disease invaded by preference parts of skin exposed to the light. Cases vary in severity. He recognized the epithelial variety beginning as a sort of raised freckle, gradually increasing in height and depth and finally ulcerating and even becoming the superficial form of carcinoma of the skin. This accords with Kaposi's views. Dr. Heitzmann has a mild case, with favorable prognosis, at present under treatment by the scraping spoon; the patient's general health is excellent.

DR. DUHRING has under treatment a case of seventeen years standing, but still of the mildest form. Here pigmentary lesions were the first to appear. On the mammæ and legs are spots like lentigo, but no vascular growth.

DR. TAYLOR added that the mothers usually regarded the disease at first as sunburn; then later, they called in some physician who generally pronounced it measles. He himself did not at first recognize the initial red spots, but had now been able to observe their appearance, and to study them with a glass in a good light, and thus verify their existence. The cause must be nervous or vascular. Later the pigment may resemble, and even be dug out like grains of gunpowder.

DR. HEITZMANN stated that the tissue between the vessels in these cases is myxoma, and the process is an angio-myxoma. Myxoma is a new formation, not an inflammation tissue, and occurs with angiomas. He would accept the new designation given to the affection.

The committee on nomenclature then made their report, which was adopted after discussion and some opposition; it will be printed later.

After the retirement of the old and the induction of the newly elected officers, the Association adjourned, to meet in New York upon the last Tuesday in August, 1879.

## Digest of Literature.

### I.

#### DISEASES OF THE SKIN.

##### ETIOLOGY, THERAPEUTICS, GENERAL TOPICS.

EDWARD B. BRONSON, M. D.

**Skin dropsy.** DR. ROBSON reports several cases of œdema of the skin, occurring apparently as an entirely independent affection. No other cutaneous disease was present, nor were there any signs whatever of renal disease. In all, five cases had come under his personal observation. Four of them ran an acute course in about a week, while one had continued for many years. All of them occurred in women engaged in household affairs—either domestics or women who did their own work. The regions of the body especially affected were the face, hands and arms, while in the chronic case the disease also affected the legs. In the acute cases a mild febrile movement accompanied the attack. Though the appearance of the patient in each instance led the writer to suspect kidney trouble, the most careful examinations failed to detect it. The cause of the disease was attributed both by Robson and by the patients themselves to "catching cold," to which from the nature of their employment they were peculiarly liable.

As to the pathology of the affection, the writer is disposed to refer the œdema to a local derangement of the excretory function of the skin, and would trace an analogy between this affection and renal disease. He thinks that the analogies of structure and functions between the sweat glands and the kidneys, together with their well known vicarious relation, suggest a correspondence in these diseases. A case similar to those described by Dr. Robson, but which was accompanied with more febrile symptoms, and was followed by an attack of typhoid fever, was related to him by Dr. Clifford Albutt, and leads the writer to remark on the possible coincidence of this disease of the sweat glands with other affections, the same as frequently happens with regard to kidney disease. The writer freely admits the insufficiency of his

observations to establish any theory with regard to the disease, but it must at least be conceded that his is a very ingenious, not to say a plausible one. *Med. Times and Gaz.*, July 6, 1878.

**Inoculability of skin diseases.** VIDAL found the pustules of ecthyma auto-inoculable in several generations. The fourth series, however, gave only insignificant pustules. The reproductive power of the pus was gradually lost. There was no diminution of the susceptibility of the individual, as shown when inoculations were made from pustules of spontaneous origin. The pustules thus produced developed perfectly. With impetigo the results were the same as in ecthyma. The writer regards the auto-inoculability of impetigo as evidence that it is an entirely independent affection from eczema, to which this property does not pertain. With regard to herpes, the result was peculiar. Sometimes the inoculations succeeded, but as a rule they did not. What the conditions were which favored the inoculability, were not ascertained. Pemphigus diuternus was not found to be inoculable. The same was true of eczema, herpes zoster and even of acne varioliformis, from which a contrary result had been expected. *Fourn. de Méd. et de Chir. prat; La France Méd.*, May 4, 1878.

**Thymol as a remedy in skin diseases.** DR. CROCKER proposes the following formulæ :

1. An ointment consisting of one ounce of vaseline, and from five to thirty grains of thymol, the thymol being dissolved in the vaseline.

2. A lotion consisting of thymol, five grains, rectified spirit and glycerine, each one ounce, water sufficient for eight ounces. The glycerine is added to correct the dessicating effect of the spirit.

3. A solution of from five to eighty grains of thymolate of potash in eight ounces of water. The alkali serves to dissolve the thymol. When the vaseline ointment is stronger than twenty grains to the ounce, the thymol should be first dissolved in alcohol in the proportion of one minim to the grain.

Thymol is an irritant to the skin in a concentrated form, but when the strength is properly adjusted, it is claimed that the remedy forms a desirable substitute for the tarry preparations. It possesses the advantage over tar of being colorless, and having a rather agreeable odor.

In psoriasis Crocker begins with an ointment of five grains to the ounce, which is gradually increased in strength, sometimes as high as thirty grains to the ounce. In eczema a weaker ointment was used (grs. iii, or grs. v ad  $\bar{z}$  j). As a parasiticide it did not appear to possess any marked superiority over other remedies in common use. *Brit. Med. Fourn.*, p. 225, Feb. 16, 1878.

**Pulvis arsenicosus asiaticus.** In view of the uncertainty of the preparations sold in this country under the name of *asiatic*

*pills*, PIFFARD has proposed a substitute that combines reliability in the composition of the remedy with elegance in the mode of administration. His formula is as follows:  $\mathcal{R}$ . Acidi arseniosi, two parts; Pulv. pip. nig, two parts; Sacch. lactis, seventy-eight parts. M. Tere bene secundum artem. He insists on the trituration being very thorough, the whole process requiring an hour's time. First one-third of the sugar is mixed with the arsenic, and rubbed together for twenty minutes; a second third of the sugar is then added and manipulated for twenty minutes more. Afterwards the remainder of the sugar and pepper are added, and rubbed with the rest. The powder is exhibited either in the form of compressed pills, or to be taken at meal times, sprinkled upon the food as a condiment. *Hosp. Gaz.*, March 15, 1878, p. 142.

**The uses of bibulous paper.** As a substitute for lint and sponges in certain surgical cases, and particularly as a dressing for chancroids, DR. FOX recommends the use of a thin porous paper, such as is used by dentists to absorb saliva in operating upon the teeth. This paper is of French manufacture, comes in sheets fifteen by twenty inches in size, and costs about \$4.50 per ream. In the treatment of venereal sores Dr. Fox claims that this paper is preferable to dry lint, and in balanitis it effects a speedy cure by simply keeping the mucuous membrane *clean and dry*. In the treatment of uterine disease it is likewise recommended.

The paper may be medicated in various ways, and used for styptic and antiseptic purposes, but its chief value is as an absorbent. *Ohio Med. and Surg. Journ.*, June, 1877, p. 202.

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## INFLAMMATIONS; ACUTE AND CONTAGIOUS.

ROBERT CAMPBELL, M. D.

**Bullous scarlet fever.** (*Scarlatina pemphigoides* or *pustulosa*.) An interesting case of bullous scarlet fever is narrated by BRAMWELL. The patient a week before admittance, having previously been exposed to scarlet fever, complained of headache, sore throat and aching in the bones. When examined at the hospital several spots which presented the characters of pemphigus were found on the skin. In some places the vesicles were broken and an ulcerating surface presented itself. On the left hand and arm

there was considerable loose epidermis, and on both legs there were many small ecchymoses. On the nates a number of red angry looking spots presented themselves, some being covered with scabs, these latter were chiefly situated in the fold between the nates and around the anus. The tongue was perfectly clean, moist, and abnormally red. The throat was considerably inflamed and there was an ash colored slough on the uvula and back of the pharynx. [The temperature was  $99.8^{\circ}$  Fahr.; the pulse 68.] The temperature never exceeded  $101.3^{\circ}$  Fahr., nor the pulse 90. A mixture of iron and quinine was prescribed, and the throat was brushed over with a solution of nitrate of silver. *Medical Times and Gazette*, Nov. 10, 1877, p. 517.

**Puerperal scarlatina.** COLSON reports two cases of scarlet fever occurring in lying-in-women. In the first the accouchement had taken place two months previous to the development of the scarlet fever, the patient being under treatment for a phlegmon of the large ligament, when one morning the body was found to be covered with an eruption which at first resembled morbilli. Four days after, the throat was affected, and at the same time the eruption took on a scarlatiniform appearance. Fourteen days after the patient was convalescing, and the disease ended by desquamation. In the second case the eruption made its appearance on the second day after delivery, there was angina, fever, and finally desquamation. The patient died of peritonitis. *La France Méd.* 1877, p. 281; *Rev. des Science Méd.*, Jan. 15, 1878, p. 183.

**Incubative period of scarlet fever.** MURCHISON in an analysis of seventy-five cases of scarlet fever arrived at the general conclusion that in not one did the incubative period exceed six days, in forty-four it did not exceed four days, in sixteen not more than two days, and in fifteen not more than twenty-four hours. Cases are given in which there was no incubative period, Dr. Richardson's personal experience of the almost instantaneous effect from exposure is alluded to, and Trousseau is quoted in a case in which the disease manifested itself seven or eight hours after the entrance of the poison into the system. M., says that, if after exposure to the scarlet fever virus, a person be subjected to a week's quarantine, and remains free from the disease, he is safe; he also believes that it is probable that a person may communicate scarlet fever to another person during the period of incubation. (Clinical Society of London.) *Lancet*, June 8, 1878, p. 833.

**Prophylaxis of scarlatina.** HARMAN gives statistics to show that hyposulphite of soda acts as a prophylactic in scarlatina. In eight families, consisting of forty-eight children, twenty-six, or sixty per cent., contracted the disease, seventeen, or forty per cent. were not effected by it, none of the patients died. He gave the hyposulphite of soda in a dose equaling about three-quarters of a grain, to each year of the child's age; four times daily to the children who were well, and every three or four hours to those who

were affected with the disease; a solution of chlorate of potassa was employed as a gargle. *Ohio Medical and Surgical Journal*, April, 1878, p. 156.

**Malignant scarlatina cured by salicylic acid.** LANDON relates the case of a child three years old, who had scarlatina of a very malignant form, in whom the palate, uvula, and nares were the seat of a diphtheritic exudation. The treatment was  $\mathcal{R}$  Acidi salicylici. 2 grammes; Syrupi simplicis. 50 grammes; Aquæ dest. 350 grammes. M. Take a teaspoonful every hour. The following injection was used for the nares:  $\mathcal{R}$  Acidi salicylici 1 gramme; Aquæ dest. 350 grammes. M. to be used twice each day. Under this treatment she rapidly improved, and at the end of three weeks was restored to health. *Clin. Méd. de Berlin*, 1878, No. 6. *Bulletin Gén. de Thérap.* August 14, 1878. p. 142.

**Ozonic ether and lard in scarlatina.** DAY gives notes of fifty-five cases of scarlet fever treated by means of a solution of peroxide of hydrogen in ether, mixed with lard in the proportion of one of the former to eight of the latter. When the throat affections were at all severe he employed a gargle consisting of two drachms of the ethereal solution of peroxide hydrogen to eight ounces of water. According to the notes fifty-three of the cases recovered, the result in the other two is not mentioned. He claims for this plan of treatment that the peroxide, being a powerful oxidizer and consequently a disinfectant in a concentrated form, destroys the poison germs before they are thrown off from the body; secondly that in consequence of the rapidity with which the scarlatinal poison is destroyed, desquamation of the cuticle seldom occurs; thirdly, that it places in the hands of the practitioner a positive means of arresting the spreading of the disease. He also believes that it can be employed in the prevention of pyæmia, erysipelas, and puerperal fever in hospital practice by having the walls painted and the floors coated with paraffine and then polished with turpentine. Geelong, 1875. *British Medical Journal*, Dec. 8, 1877, p. 806.

**Sulpho-carbolate of soda in scarlet fever.** RISQUE believing that scarlet fever is due to the presence of zymotic germs which enter and multiply in the system, treats all such cases with sulpho-carbolate of soda and chlorate of potassa, eight grains of each every three hours; if there is a severe inflammation, gum guaiacum may be used in conjunction with the above mentioned remedies. As a prophylactic the sulpho-carbolate of soda in same proportion every five or six hours will ward off the disease. *Louisville Medical News*, May 18, 1878, p. 238.

**Sulphurous acid in scarlet fever.** WATERMAN reports eleven severe cases of scarlet fever treated by sulphurous acid in doses from 10 to 30 drops every two or three hours, diluted. Ten of his patients recovered, and one died in forty hours, from chills with cerebral congestion. *Practitioner*, March, 1878, p. 184.

### Scarlatinoid eruptions in the ague of young children.

CHEADLE narrates two cases in which an eruption resembling scarlatina developed during an attack of ague. The first a child two years and nine months old, and who was teething, was suddenly seized with a sharp shivering fit; a hot bath was given, after which a bright scarlet rash appeared all over the body, accompanied by dry burning skin, a high temperature and quick pulse. This condition lasted about three hours, when the febrile symptoms subsided and the rash disappeared. The next morning about two hours earlier than the previous attack the same train of symptoms were renewed, and it was at this time that Cheadle first saw the patient. He described the rash as being scarlet, punctuate and covering the whole body, there was, however, no sore throat, and the tongue did not present the strawberry-like appearance. Two grains of calomel were given and the symptoms subsided, there was a renewal of the rash on the next day. The patient was cured by means of quinine and it was ascertained on careful inquiry that she had been previously exposed to ague, having been in a malarial district. The second case was somewhat similar, with the exception that the rash only made its appearance once a week. Quinine was given to this patient also. *British Medical Journal*, April 13, 1878, p. 521.

**The connexion between measles and rōtheln.** BRISTOW believes that rōtheln and measles are not mutually protective, consequently they are not modifications of the same disease; also that rōtheln is not so contagious as measles. In support of this, he says, that nine years ago all of his children, seven in number, had measles, five years afterward his two oldest daughters were attacked with rōtheln, the remaining five children, together with two others although exposed to the disease did not have it. Subsequently, the two youngest children were exposed to the poison of measles and contracted the disease. He has witnessed other epidemics and with the same results. *Lancet*, August 25, 1877, p. 296.

**Variola hemorrhagica.** BULKLEY reports a second case of this rare form of small pox, occurring in his practice within a year. The patient, a lady 39 years old, was seized with a slight chill followed by malaise. Two days after this she began to get flushed in the face, these flushes were of a purplish and rather lived hue, and on the third day some ecchymotic spots appeared on the neck and chest. There was not much pain in the back during this period. During the first few days of the disease there was no sign of papulation, nor at any time an amount of any lesion that would be considered distinctive of small pox. Hemorrhages from the mouth began on the third day and soon extended to other localities, persisting until death. Twelve hours before death, when B. saw her last, the face presented an evenly distributed, purplish, livid hue, with few, if any blotches, but scattered over the purple

surface a few minute papules could be discovered when examined closely. The neck and chest were covered with a thickly set eruption of petechiæ, confluent in some places; on the abdomen, where a mustard plaster had been previously placed, there was an evenly formed ecchymotic surface; the back was pretty well covered with petechiæ. On the thighs the hemorrhagic spots were separate and distinct, of an irregular, roundish shape; they were more thickly set upon the buttocks. The legs were more sparsely sprinkled with them, they, however, reached down to the toes. The arms were affected in the same way, the eruption of hemorrhagic macules of various sizes and shapes, extending on to the hands and even to the fingers, chiefly on their extensor surfaces. Many of the petechiæ, on close inspection with a pocket lens presented minute pustules, although a comparatively small number of the hemorrhagic spots exhibited them. There were several pustules with ruptured summits in the roof of the mouth. The eyes were intensely ecchymotic, the right more so than the left. The mouth and nose were pouring forth blood, blood also passed by the bowels, there was considerable pain in the abdomen, and the urine was loaded with blood in streaks and clots. Pulse was 120, full and throbbing, temperature  $104^{\circ}$ ; tongue dry and parched. The patient was conscious. Fluid extract of ergot was given but the patient succumbed to the disease.

In regard to diagnosis, he says that it could not be purpura hemorrhagica, as there would in that case have been no initial chill, nor the fever and throbbing pulse of 120, nor the papules on some ecchymoses and the vesicles and pustules on others. Black measles, or black scarlet fever, the hemorrhagic varieties of these diseases would also never give the pustular element, would not be so rapid in progress, nor so violent in character, besides in measles there would be catarrhal symptoms, and in scarlet fever we would expect to have sore throat.—*New York Med. Record*, April 27, 1878, p. 325.

**Isolation of small-pox cases on ship board.** A good example of the effect of isolation of small-pox cases in preventing the spread of the disease was shown on the ship *Hermione* with four hundred and fifteen coolie emigrants on board, when five days out one of the passengers presented symptoms of variola. The physician in charge had one of the boats, which was lashed to skids above the deck, turned into a hospital, roofing it with matting and placing a tarpaulin over this. The patient was removed to this boat, fumigated and disinfected. Four other cases made their appearance; they were removed to the boat, which was kept thoroughly fumigated and disinfected. The five patients recovered, there were no more cases on board, and the ship arrived in port free from disease.—*British Med. Journal*, June, 1, 1878, p. 803.

**Is umbilication of the vesicle a diagnostic sign of**

**small-pox ?** ALDERSON gives the case of a boy who had varicella and in whom there were several vesicles which were umbilicated. The diagnosis of the disease being varicella and not variola was formed from the following symptoms : the slowness of the illness, the rapidity of the appearance of the eruption, being fully out in twenty-four hours ; the number of vesicles on the head, and the small quantity on the face. The scabs fell off on the evening of the third day, those of variola would remain until the ninth or tenth day. There was also no period of incubation. Alderson therefore believes that no reliance can be placed upon the umbilication of the vesicle as a diagnostic mark of variola. *Lancet, Feb. 9, 1878, p. 223.*

**Treatment of variola by painting with iodized glycerius.** PIOCH recommends the following treatment which he has successfully practiced in an epidemic of small-pox. During the first three days, if there be delirium, he administers quinine and musk. When the eruption is well out and delirium ceases, during the three following days the above treatment is discontinued, and sudorific drinks are given. Towards the end of the seventh day, when the fever which had subsided returns under the influence of the maturing pustules, the whole surface of the body, commencing with the feet and ending with the face, is painted with a brush dipped in a mixture of three parts of glycerine and one of iodine. At the end of the fourth day of suppuration, the twelfth day of the disease, when the fever diminishes, the inunction is discontinued and the cure is awaited. Pioch had nine bad cases of variola under his care, of which the first, which was not treated with the iodized inunctions, died. The eight other patients, seven of whom had confluent small-pox, went on well to the last stage and were cured in the usual time.—*Lyon Médical, May 21, 1877, London Medical Record, March 15, 1878, p. 129.*

**Carbolic acid in small-pox.** LOWE has used carbolic acid externally with success in small-pox. The advantages claimed are the prevention of pitting and diminution of the febrile action. He mentions a case of confluent small-pox in which the entire surface of the face, neck, hands, and arms was painted over with the strong acid, a portion at a time. A few seconds after the acid was applied, a piece of blotting paper was employed to remove the excess of acid, after which the surface was dressed with lint in order to relieve the smarting sensation which was produced. The skin became dry and parchment-like ; no pustules made their appearance where the acid had been applied, while the rest of the body was covered with them. After desquamation no trace of mark remained and there was less redness. The dryness of the skin was removed by anointing with salad oil. There was discoloration of the urine from the absorption of the acid. L., says that this might be obviated by painting a small patch of the eruption with the acid at each visit, washing with warm water immediately afterward, and also giving alkalies internally.—*Lancet, Aug., 3, 1878, p. 169*

**True animal vaccination.** MARTIN says that vaccination performed with the true animal virus possesses several decided advantages over that in which humanized lymph is used. First in case of an epidemic we can always have an unlimited supply of virus, whereas if humanized lymph is employed the demand will soon exceed the supply; and also that the protection afforded is not so great from the latter as from the former method. Second there is an entire immunity from erysipelas when true bovine virus is employed. Third there is a freedom from liability to induce the irritable spurious vesicle.—*New York Medical Record*, April 20, 1878, p. 304.

**Animal vaccination.** WARLOMONT says that "if one inoculate syphilis to a calf, the latter does not take it, the virus dies on the spot. If one inoculate syphilitic vaccine to a calf, the syphilis remains outside, and only vaccine develops itself. The latter is certainly free from any trace of syphilis. Heifer vaccine, whatever be its source, can never, therefore, give syphilis." He concludes by saying that if syphilis is communicated it is because several persons are vaccinated at the same time and some contaminated blood is conveyed on the point of the lancet. To avoid this, charged lancet-shaped ivory points should be used.—*Lancet*, July 13, 1878, p. 70.

**Erysipelas and vaccination.** LODGE says that erysipelas may be prevented after vaccination by painting an inflamed areola with the tincture of the perchloride of iron. He also says that there is no danger to be apprehended in vaccinating with the same lancet for any length of time, care being taken, however, to purify it by means of water after every time it touches the new patient.—*British Med. Journ.* June 22, 1878, p. 891.

**Vaccination and re-vaccination.** ATKINSON believes that syphilis cannot be communicated by means of vaccination unless through carelessness, the syphilitic matter being inoculated instead of the vaccine virus. When skin eruptions follow vaccination the fault is not necessarily with the lymph but often with the constitution of the child vaccinated. From the statistics given it is shown that humanized vaccine matter is preferable to the bovine virus, the former yielding the greater percentage of successful vaccinations. In conclusion he says that vaccination lessens the chances of taking small-pox, though it does not render the reception of it in after years altogether impossible; that, in most cases, it greatly modifies the character of the eruption and lessens the severity of the attack; and that re-vaccination gives an almost absolute immunity from small-pox provided it is efficiently performed after fifteen years of age. Atkinson believes that the disease can be banished altogether by means of vaccination and re-vaccination and in no other way.—*British Med. Journ.*, June 22, 1878, p. 892.

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## NEW FORMATIONS.

EDWARD WIGGLESWORTH, M. D.

**A very extensively diffused case of lupus erythematosus.** JAMIESON reports an example of lupus erythematosus presenting peculiar characters and distributed over a large area. The left cheek had been affected for twenty years, the hands and feet for eleven. Four years ago patches appeared upon the nose and soon after upon the right cheek, ears, face, forehead and neck. No subjective sensations of itching or burning, only stiffness and diminished power of flexion of the fingers. No oozing; occasional bleeding from fissures, scaliness, and habitually cold hands. The nose at present presents the features of the true lupus erythematosus of the Germans, fully developed; the hands, and some other

parts, the characteristics of the erythematous lupus of some English writers. (Hutchinson et al.)

A bit of skin from a patch of recent date upon the lobe of the ear, presented on section, after hardening, the following appearances: Around the hair follicles large, dense accumulations of cells, each small, round, and somewhat granular. Here and there round spaces or alveoli with a wall composed of fine fibres. These spaces existed in the corium, a few however in the epidermis, some even bursting on the free surface, probably representing milia, arising, as shown by Newmann, from destruction of a hair follicle or the lobule of a sebaceous gland. Epidermis thin, otherwise normal.

Another portion was taken from a patch of eleven years standing, on the back of the hand. Here the surface of the horny layer was flaky and at one part there were swollen cells apparently impregnated with colloid material. The layer of Langerhans, separating the horny from the mucous layer, was distinctly marked as a bright band composed of condensed cells. The mucous layer was normal, the rib or prickle cells being very clearly seen. The papillæ were enlarged, more in breadth than in height. The corium was infiltrated, especially its deeper layers. Here the cells were in parts so thickly packed as to obscure almost entirely the fibres, the tissue becoming so friable that here and there the continuity of the section was broken. The cells occupied the finer portion of the corium, ceasing where the structure resembled areolar tissue. The development was evidently from below upwards. The cells were small, round, granular, and distinctly nucleated. Glands and follicles destroyed.

Some of such cases appear almost to bridge the interval between the erythematous form and the superficial, non-ulcerating form of lupus vulgaris, when the tubercular element is more, the erythematous less, strongly pronounced. Though the disease arises as a rule near the hair follicle, in and around the sebaceous glands, yet, in rare cases, after long continuance, similar morbid changes are found where the sebaceous glands are few or absent. Neumann mentions a case where it was met with on the palmar surface of the hand—a feature observed also in the present instance.

The case is improving under treatment with Hebra's Spiritus saponat. kalinus, and Unguent. diachyli, varied with 10 Grains of oxide of lead in 30 Grains ung. petrolei. *Edinburgh Med. Jour., May, 1878, p. 1006.*

**Lupus, syphilis, and superficial epithelioma, with a communication upon a rare form of lupus, lupus cornutus.** LANG regards the term "syphilitic lupus" as unwarranted and as a confession of ignorance. Etiologically, if the cause is syphilis the result is syphilis, not lupus. If lupus and syphilis coexist they are two distinct processes and should be spoken of as such. Accurate distinctions are the basis of sound teachings. It is true, as Auspitz states, that, in rare cases, a syphilitic infiltration evinces a

marked chronicity, but in lupus this is always the case, and the usual rapid and sometimes "acute galloping" course is not met with. The diagnosis between the two diseases is not always easy to make, but the processes are in fact as distinct as they are later, when the indisputable results of the existing process have removed all doubt. As a rule, however, the characteristics of the two diseases vary to such a marked degree that many a worthy physician has so accurately described his case of "lupus" as to prove beyond a doubt that his diagnosis should with justice have been syphilis.

The superficial form of epithelioma is also often confounded with either lupus or syphilis. It is therefore in place to report here a case of *lupus hypertrophicus*, which might with justice be termed *lupus cornutus* and which differs from all cases hitherto reported, since this would have been regarded by most observers as epithelioma. Even v. Langenbeck, says (*Berl. Klin. Wochenschr.*, 1875, p. 330.) that horn-formation may accompany one form of carcinoma of the skin but has never, to his knowledge, been observed in cases of lupus.

The patient, a girl of thirteen years, had upon each cheek an extensive patch of apparently hypertrophic lupus except that the papillary outgrowths, instead of being covered as is usual by a crust, were composed throughout of horny layers of epithelium piled one upon the other; were in fact veritable cutaneous "horns." These were easily removed. The base was dry and covered with little cones, either discrete, or arranged in prominent and continuous ridges which were either twisted or straight. As the disease approached the neck, this condition gave place by degrees to the usual, perfectly characteristic form of an ulcerating lupus hypertrophicus.

I have already shown (*Mediz. Jahrb.*, 1876,) the anatomy of hypertrophic lupus. "The outgrowths from the papillary bodies do not all ulcerate. Their epithelial covering, nearly everywhere present, is so thin that the grouped papillæ show through like granulations, here and there even protruding as a sessile, or pedunculate, peg or even hanging over like a proboscis. Or, a single papilla may develop to a long horn, covered with thick, close layers of epithelium." The flat form of epithelioma, formerly called rodent ulcer, is often regarded as lupus and still more often as syphilis. It appears as slightly, or not at all, depressed and is surrounded by a low, hard, pale or pale-red border, which is uneven and often somewhat striped. Or it may appear as a raised ulcer with a well defined, abrupt margin. The secretion is always slight, drying speedily to a thin crust. The deeper tissues may become involved while the disease is also spreading peripherally. The cancerous infiltration is however thin. As soon as a lower layer of tissue becomes infiltrated the preceding one suppurates away. The result of this is a bowl-shaped concavity. As the disease although superficial is not therefore always "flat," it may be preferably characterized by the former adjective. One

symptom, common to this and other forms of carcinoma, is the pulling inwards and contracting of the surrounding healthy skin, and the older the disease the more marked is this condition. (See also *Wiener Klinik*, 1876.)

Syphilis may develop upon a person having lupus. This was proved by Waller's experiment twenty-seven years ago. Syphilitic gummata have not been known to occur upon lupus infiltrations, though this is theoretically possible. Nor has carcinoma been known to develop upon a syphilitic infiltration of the skin; while, upon lupus, carcinoma has frequently been seen. (*Vierteljahresschr. für Dermatologie und Syphilis*, 1874.) *Wien. Med. Presse*, Nos., 6 and 8 Feb. 1878.

**Lupus syphiliticus and scrophulosus.** PROFESSOR AUSPITZ, of Vienna, in this paper (*Separatabdruck aus der Wiener Mediz. Presse.*) replies to a communication of Kaposi, in which the latter maintains that the former title is a misnomer, as there is no such process as a syphilitic lupus. To show the more plainly the differences of opinion between himself and Professor Kaposi, Auspitz sets forth in the beginning the points of belief in which all observers agree concerning the nature of lupus, as follows:— (1) Lupus is a so-called granulation-new-growth, consisting of embryonic cell elements which never advance to any higher development,—an infiltration, such as also characterizes syphilis, scrofula and leprosy. The character of this “granuloma” as an independent form of new growth was first established by Virchow. (2) The development and seat of this granulation-new-growth is exclusively in the tissues of the corium. (3) The small-celled granulomas occur in the form of more or less sharply defined, larger or smaller foci, which betray themselves externally by the development of nodules of dark-red color and firm consistence. They often unite to form flattened elevations, and spread outwardly, sometimes subsequently with crescentic borders. (4) Their elements being incapable of farther development beyond a certain point, they retrogress by softening, undergoing caseous degeneration, suppurating, ulcerating; or they atrophy, and leave behind cicatricial contractions. (5) These processes have a general character of chronicity in all their stages of development and retrogression.

These characteristics are common to all the granulomata of the skin, but the clinical distinctions usually made between the lupus form and others are thus stated by Auspitz: The ulcers of lupus as well as of syphilis are often round, and have sharply defined edges, but the former are at the same time flat, scarcely if at all painful, and have red, granulating and easily bleeding edges; those of the latter, on the other hand, are very painful, with edge and base thickly infiltrated and coated. Lupus never begins except in the form of small papules deeply imbedded in the corium; not as large palpable nodules from the start. There is never to be observed in individual lupus nodules the constant peripheric pro-

gress and analogous degeneration as in syphilis, and therefore the ulcer of lupus never has the kidney form. The nodule of lupus progresses more slowly than that of syphilis. Destruction of the nasal bones and perforation of the hard palate do not occur in the former, often in the latter. Lupus begins always primarily in early childhood ; syphilis may begin at any age. In the lupus papules the stick of nitrate of silver penetrates easily ; not so in the nodules of syphilis. The latter, both when fresh and ulcerating, disappear, as a rule, with surprising quickness under mercurial plaster ; those of lupus do not, nor are they influenced by other antisyphilitic remedies.

That there are cases which are as abruptly defined, and can be as readily distinguished from scrofulous and syphilitic lesions of a similar character, as above represented, Auspitz does not deny ; but he maintains that these are exceptionally typical in character, and that it is impossible to distribute a series of cases under any such sharply defined rules of classification. With him lupus must have a much broader clinical significance. He would apply the name to a group of symptoms which develop upon the anatomical substratum of a granuloma, and are characterized clinically by the persistence, continuous relapse, and the slow degeneration of their nodular, flattened, and often serpiginous forms of eruption, which sometimes are scaly, sometimes ulcerate, and sometimes atrophy into cicatrices without ulceration. Under this definition he believes that certain forms of inveterate and hereditary syphilis may properly be called syphilitic lupus ; and the same holds true, in his opinion of scrofula. Dr. J. C. White, in *Boston Med. and Surg. Jour.*, June 20, 1878.

**Lupus of the larynx a clinical study.** LEFFERTS quotes ten cases of this rare disease as upon record. In all but one, lupus of the cutaneous surface likewise existed. After giving his own case in full, and reiterating with Von Zeimssen the "urgent need of further observation both with regard to laryngeal lupus generally, and in particular with regard to its therapeutics," he gives the following conclusions :

1. Lupus of the larynx, from our present experience of it, must be regarded as a rare disease.
2. Seven unquestionable cases, and three doubtful ones, are alone upon record. In all of the former, lupus of the cutaneous surface (face, neck, back, arms, etc.) co-existed.
3. The diagnosis may be made from the peculiar and perhaps characteristic appearance of the pharyngeal parts, the nodulations, fleshy granulations and ulcerations of the epiglottis primarily and specially, the clinical history of the patient, and the concurrent signs of lupus of other parts.
4. The differential diagnosis is not unattended with difficulty. Laryngeal tuberculosis, syphilis and carcinoma all present certain points of similarity to lupus, especially the first named. From

the two last, and likewise from *œdema glottidis*, chronic follicular laryngitis, etc., if may readily be distinguished. The pharyngeal appearance, the peculiar aspect of the epiglottic lesions, and the extent, location and pathological character of the concomitant ulcerations, together with the clinical history and manifestations of a cutaneous lupus, will serve, if care be taken, to distinguish laryngeal lupus from laryngeal phthisis; as, in the latter affection all of the above mentioned signs fail and are replaced to a great extent by others, which are certainly different and generally regarded as diagnostic. These points are alluded to in detail in the article.

5. The prognosis is unfavorable, and the site of the disease at the entrance of the air passages, manifestly exercises a marked influence as regards danger and duration.

6. Treatment is more or less empirical, being based at present simply upon what experience has taught of the treatment by destructive agents of the concomitant affection of the skin. Nitrate of silver and cod-liver oil appear to have been of service in certain instances, while in others they have failed. In still others a sedative and entirely unirritating treatment has succeeded best, if not in effecting a cure or even arrest of the disease, at least in giving marked relief. Upon this question further light is earnestly to be desired. *Amer. Jour. Med. Sciences*, April, 1878.

**Indigenous leprosy.** GASKOIN alludes to fifteen cases of certain, probable, or possible leprosy, occurring indigenously in Great Britain since 1806, and shows his acquaintance with the various pseudo-synonyms of this disease. The exciting cause of one of these cases he discovers to be a "too exclusive diet of bacon" on the part of the patient, "agreeably to the habits of his class in Wilts and the adjacent counties." (!) The diagnosis of another, and a very doubtful case, was established by taking the patient's Bible into consultation. One case, than which "there never was an example more unmistakable," was in 1852 diagnosed by Addison as "spurious leprosy," whatever that may be, because, in spite of the fact, theory said "that leprosy could not happen in England." Gaskoin inclines to the antique belief in contagion; holds fast to the theory of diatheses; is dubious whether leprosy is a "disease or a dyscrasia" "still active among us;" suggests "something of identity" between leprosy and elephant-leg, "the two forms of elephantiasis;" would refer "penetrating plantar ulcer to the category of lepra-anæsthetica," and is inclined to insist that certain cases, reported in England under the head of gangrene of the skin (and notably by Brodie) are no other than forms of "leuce." (?) [And yet dermal histology will next year lack an exponent in the Royal College!—**REP.**] *Med. Times and Gaz.*, January 29 and May 4, 1878.

**Modern Indian leprosy.** CARTER published in 1874 a large work on leprosy, under the sanction of H. I. M's. Secretary

of State for India in Council ; also Official Reports on the leper asylums in Norway (1874), and a second series on leprosy in north Italy, Scio, Crete and Palestine; issued under the same authority (1876). He now reports the results of an Indian tour, undertaken at the expense of the Chiefs of Kattiawar, and gives a detailed list of lepers (official), including 601 affected individuals. He considers that leprosy has nothing to do with such wide features as either the race or social habits of a mixed people, and that experience hitherto tends to show that—(1.) Villages with lepers are not necessarily in main features any way different from those not so infected, (2.) no special caste is peculiarly liable to leprosy, nor an affected individual necessarily the poorest or physically the weakest, etc. ; (3) insanitary conditions are so universal that one's attention is apt to be perplexed; yet no one defect has as yet seemed to call for special notice ; (4) the difficulty remains why only one or two persons are affected amidst a large number to all appearances placed in identical circumstances ; (5) heredity is by no means a universal feature of leprosy ; (6) sources of contagion can probably never be absent ; yet it is practically impossible to trace ordinary cases to this origin, and difficulty No. 4 still remains. The clue, therefore, to the cause and spread of leprosy is yet wanting. In other words more information is needed, which can be gathered after a prolonged and thorough inquiry. As to the topographical and political areas of leprosy, the two most prominent facts elicited are that—(a) Leprosy is most predominant in populous coast areas, less so inland ; (b) The disease subsides also north of the Phaonagar creek and hilly range, in directions where both coast and inland areas exist, and in the Bhal, a considerable, rather barren maritime area, leprosy is quite absent, showing that mere proximity to the sea has nothing to do with the disease.

The method of dissemination deserves attention. Thus the chief town always represents a chief 'focus' (whether of radiation or concentration) ; next the villages immediately around are affected, and beyond these pass off, as it were, 'lines' of leper-localities in various directions, which may meet and blend, or become continuous, with similar lines in adjoining districts.

This may be said to point to transmission of the leprous disease by means of human intercourse.

The forms of leprosy are the nerve-lepra or anæsthetic leprosy, and the more severe tubercular form. In West India the former predominates ; in Norway, Crete and Syria the latter. Women are more subject than men to the milder affection. Age seems to hold no special relation to the appearance of either form ; temperament does not vary as among Europeans, though it seems as if the "lymphatic" habit of body is more often associated with nerve disease than the "spleen" habit.

The disease begins very frequently, at least, upon the exposed parts of the body, the face, feet and hands. Male lepers are in



India greatly more numerous than leprous females. The disease is found most prevalent during the most vigorous periods of life. Leprosy may begin at any period after birth, but does not seem to be congenital. It attacks all castes and races, but probably does not attack them proportionately to their respective populations, preferring rather certain groups, large or small, in certain areas; and this doubtless in accordance with local events, which must be specially investigated. No new facts were detected in regard to the influence of occupation in inducing lepra. The malady is endemic in certain districts, and occurs sporadically around them without assuming the character of a true epidemic. After gaining a footing it may slowly spread in some directions and decline in others, without following any method or regular course.

As the rule, lepra only appears among bodies of people numbering upwards of 400 to 500, and is apt to show itself at about the same time in those affected, this correspondence as to date leading to the inference that some co-temporary or local cause is then in operation. Men or women with marked lepra have not seldom large families. About 30 per cent. of all lepers have some direct or collateral taint. The disease has nothing to do with syphilis. Direct contagion cannot be proved. No particular diet has been shown to cause leprosy, and while it flourishes under bad hygienic conditions it cannot be said to arise from them.

Dr Carter recommends the complete isolation of the leper; and, if possible, his removal to a suitable asylum. The volume concludes with "Addenda on modern Norwegian, Cretan and Syrian Leprosy." *Modern Indian Leprosy. A Tour in Kattia-war, Bombay, 1876.*

**Leprosy.** ROHÉ very justly regards the so-called "Lepra" of "Leviticus" as psoriasis, and that of "Naāman the prophet," as scabies; the Hebrew *Zaraath* (with some restrictions), the Arabian *Fuzam*, the Greek *elephantiasis*, the *Lepra* of the Greek and Latin translations of the Bible, of the middle ages, and of the modern German authors, as Leprosy. The *Dal-Fil* of the Arabs is the *elephantiasis* of the middle ages, the elephant's leg, Boucnemia tropica, Barbadoes leg, elephantiasis arabum of the moderns, and has no pathological relations whatever with leprosy.

The lepra of the early Greek writers was psoriasis. In the middle ages before syphilis was recognized, this too was confounded with leprosy.

Fifty cases of true leprosy have been observed in the United States. ROHÉ gives three endemic cases where heredity was positively excluded by the history, and where the disease could not have been due to contagion, nor was it communicated to others, nor even to a spouse who reported "repeated intercourse since the disease first appeared." He would regard the disease

as more aptly classed with such affections as lupus, psoriasis or cancer, which depend upon a peculiar disposition, hereditary or acquired, but of whose ultimate causes we know absolutely nothing.

Thus psoriasis, lupus and cancer are not considered contagious by any well informed physician at the present day, while the current belief in the heredity of cancer is rapidly losing ground since we can, so to speak, produce cancer at will.

Although lupus and psoriasis appear to be transmitted in some instances from parent to offspring, no one will venture to claim heredity as a cause of either. It seems clearly, therefore, to be more philosophical to confess our ignorance of the causes, either immediate or remote of leprosy, than to assume this or that factor as explaining its origin. The impression Dr. Rohé attempts to convey is that leprosy is not a specific, pathologically definite disease depending upon a known cause, but, that it consists in a profound disturbance of the economy, analogous to, or more properly homologous with cancer, beginning perhaps in the nervous system, occurring in all parts of the earth, and affecting individuals of all classes; the origin and nature of which remain for the present unsolved problems.

The pathological anatomy of leprosy has been carefully studied by Virchow, Kaposi, Carter, Neumann, and others. These investigators found the skin, nerves and certain internal organs infiltrated by small, round, closely-packed nucleated cells, resembling the cellular new-formation in lupus and syphilis. These cells may undergo fatty degeneration, softening and resorption, but have usually more stability than those of the other affections mentioned. The infiltration of the nerves explains the changes in sensation, there being first hyperæsthesia in consequence of pressure upon nerve fibres, and later anæsthesia, on account of abolition of function of the fibres consequent upon the increasing infiltration. The prognosis is unqualifiedly bad.

Although patients may be rendered much more comfortable by good food and other hygienic measures, complete recovery is not to be hoped for.

The treatment to be of any value, can only be symptomatic. *Maryland Med. Jour.*, July, 1878.

**On an inflammatory fungoid form of tumor of the skin.** In the annual report for 1873, of the Skin Department of the Vienna General Hospital, and subsequently in the *Vierteljahrsschrift für Dermatologie und Syphilis*, Dr. Hans Hebra reported under the title of "An Unusual Case," the case in question. Such titles cannot be too strongly reprobated. They have nothing to distinguish them. They cannot be referred to; the case passes from memory and is lost. GEBER who preceded Hans Hebra as clinical assistant and in whose service the case occurred, reports it now more at length.

A previously healthy, well-nourished, Hungarian tailor aged 47 years reports malaise, and severe itching two years previously, from no known cause. Groups of small vesicles appeared upon the face, itched, were scratched and spread.

The disease spread downwards over the throat and chest, the neck and back, and by degrees over the whole body. At times some slight relief has been obtained by treatment; subsequently, however, relapses took place, and for the last six months his condition has been much worse. During this time tumors have appeared, at first upon the face, subsequently upon the rest of the body. Some of these appeared upon spots of previously diseased skin, others came where the skin was healthy. Of these last some have of themselves disappeared. Fresh manifestations appear as scattered, pin-head sized, papules and pustules, with brown scabs where scratched. Those rather older appear as large patches either covered with vesicles and crusts, or, having lost these, cracked and exuding.

The healing patches of longest duration are infiltrated and covered with scales, no longer swollen but with a dark pigmentation. Everywhere, but especially upon the normal skin, are light-red, hard, fungoid elevations several mm. in height and four cm. or less in length, either smooth or fissured. Near the *pomum adami*, on the right and left upper arms, in front of each axilla, and on the inner aspect of each thigh are seated pedunculate, elastic, highly vascularized tumors, from a hazel-nut to a goose-egg in size, with lobulated surfaces in places excoriated or covered by yellowish brown crusts.

Universal lympho-adenitis exists; pulse 76, temperature in axilla 37.4 R., no albumen in urine. From August 8, 1872, to January 27, 1873, the patient was under daily observation. During this time there was much pruritus, relieved by tar; various degrees of eczema; suppuration of various glands and formation of abscesses, one yielding nearly 150 c.c. of pus.

November 19. Fever set in with severe pruritus.

January 11th to 19th. Fever continued: new tumors appearing and rapidly suppurating; moist eczema spreading.

January 25. Diarrhœa.

January 27. Erysipelas migrans starting from the back spread over the body; at noon, chills and coma; at 7 P.M., death. At the autopsy the principal abnormal condition shown was peritonitis with exudation of pus into the cavity of the abdomen. The internal organs were all anæmic.

Geber furnishes in minute detail the results of a carefully accurate microscopical examination of the tumors of the skin. He regards the pathological process as identical with that described in 1864, by Köbner, under the title of "Fungoid Multiple Papillomata." Köbner regards the disease-process as local, some others hold that it is partially or entirely constitutional. It is not contagious; not hereditary; presents itself with or without prodrom-

mal fever, is subacute in the form of hyperæmia and exudation into the superficial layers of the cutis; may endure for years without affecting the general health of the individual, and death is due to some intercurrent complication. He considers that the process begins in the connective tissue of the corium; develops by growth in length and breadth of the papillæ, which crust but never ulcerate very deeply; and is a disease sui generis, to be classed among the granulation tumors of Virchow. Geber adds that it is entirely distinct from syphilis and belongs in a common group with Hebra's rhinoscleroma and Kaposi's dermatitis papillomatosa. A handsome chromo-lithographic representation of a picture of the patient, from nature, by Dr. Heitzmann, accompanies GEBER's paper. *Deutsches Archiv. f. Klin. Med. XXI., Bd., 1 and 2 Heft, 1878.*

**Nerve-nævus.** NEUMANN showed a case of this rare disease to the College of Physicians of Vienna. He retains in preference to neuropathic papilloma of the skin, the original name of nerve-nævus given by Th. Simon. The influence of the nervous system upon the skin, was alluded to as shown in anæmias and hyperæmias, or by increased or diminished sweat-production due to mental influence. It is now known that some diseases of the skin arise immediately from disease of nerve ganglia or of the peripheral nerve terminations. Such are cases of zoster. Alopecia originates in some cases from disease of the trophic nerves. The prodromal exanthem of variola is attributed by Th. Simon to paralysis of the vaso-motor nerves, and purpura variolosa has been found by Neumann coincident with and probably dependent upon disease of intervertebral ganglia and the spinal column. Anæsthetic leprosy also is essentially a disease of the nervous system.

Of the disease in question, nerve-nævus, V. Bærensprung saw and reported the first recorded case. Other cases have since been observed by Thomson (nævus papillaris); by Th. Simon, who gave the name nerve-nævus to the disease and distinguished vasomotor and trophic nerve-nævi; by Gerhardt, (neuropathic papilloma of the skin); by Beigel, (papilloma area elevatum); by Geber; by O. Simon; and by Campana, (eleven cases of nævus).

NEUMANN's case was congenital, upon a first-born child of the female sex and well developed. On the right nates and lower extremity are prominent, dull white outgrowths arranged in regular lines and bands, appearing to the sight upon the soles like blisters, but evidently consisting of firm hypertrophied papillæ the size of millet seeds; and arranged on the outside of the upper thigh, in bands from 1-2 cm. broad, on the perinæum and around the labia majora are circular bands some 3 mm. broad. On the outside of the lower thigh are three linear bands about 1 cm. long and 2 mm broad. On the dorsum of the foot are three parallel stripes 5 mm. broad, one from the heel to the little toe, one to the second and one to the fourth. This last is 1 cm. broad. On the sole are two stripes 5 mm. broad begin-

ning at the heel and extending to the little and fourth toes respectively. These distributions of the new formation correspond accurately to the distribution of the cutaneous nerves of these parts. The growths increased during the first two months of life, assuming upon the soles a yellowish color; they then disappeared by degrees, first from the calf, next from the thigh and finally from the thigh, and finally from the feet. The points of special interest here are :—

I. The complete development during intra-uterine life.

II. The spontaneous cure, whereas nævi generally increase.

III. The evidence that ichthyotic formations can be congenital.

*Wiener Med. Presse*, No. 51, 1877.

**The diagnosis of multiple neuromata.** GERHARDT refers to eight valuable papers upon neuromata and cites four cases of the disease occurring at Würzburg, together with his own (the fifth); this last at length, with the autopsy. Also two cases occurring at Dublin, one case reported by Hensinger in Virchow's Archives, and the pathological preparation of a rare case reported by Wegner, (*Virchow's und Hirsch's Jahresh. Bd. I., p. 304*). He considers that there have now been enough cases reported to warrant comparison of and a careful judgment upon the facts in these cases. Thus it might perhaps be possible to make a diagnosis before the patient reached the post-mortem table.

Multiple neuromata may exist upon a nerve or branch only, or may be scattered over the body upon many different nerve-trunks. They are composed of nearly the same number of fibres as the afferent and efferent nerves. The mass of the tumor consists of connective tissue distributed between the nerve fibres. The tumors may be medullate, non-medullate, and ganglionic, all coexistent in the same individual. The process might be regarded as a multiple sclerosis of the peripheral and sympathetic nerves. The nerve elements are not destroyed nor robbed of their functions. The process is more frequent in men than in women. It appears to be hereditary. Five cases are reported of the disease affecting several members in a single family. Where one case occurs, other members of the family often suffer from nerve-diseases even when these are not neuromata. The neuromata are usually found at the autopsy to be much larger than had been supposed during the patient's life, as they frequently lie under the skin. They occur with their longest diameter in the longitudinal direction of the nerve, the course of which they may mark out when numerous and closely pressed together. They feel hard like cartilage. They are very movable and much more so laterally than longitudinally. Isolated ones may be painful and tender on pressure, multiple ones just the reverse. They may exist from early childhood or the latent predisposition may be aroused later in life by exposure to cold. The extirpation of single ones seems often to cause the more rapid growth of those remaining. Hips, shoulders and neck are the

favorite locations of the larger forms which here may have a rough or even lobulated surface. Kupferberg, reports a case of neuroma of the lower extremities resembling even elephantiasis. It succeeded a fracture, the cause probably of the rapid and extensive growth.

The physiological diagnosis of neuromata seems to be possible by the aid of galvano puncture; a very weak stream thus applied causing a twitching of the muscle to which the nerve belongs. *Deutsches Archiv. f. Klin. Med.*, 5 März XXI Bd. 2 und 3 Heft, p. 268.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### GENERAL QUESTIONS IN SYPHILIS, THERAPEUTICS, ETC.

E. I. KEYES, M. D.

**On the question of the innocuity of certain physiological secretions in syphilis.** Dr. J. NEVINS HYDE'S excellent paper consists in an admirable critical examination of the following papers:

1. Is syphilis transmissible through the milk? R. Voss. *St. Petersburg Med. Wochenschrift*, No. 23, 1876.

2. The question of the innocuity of the milk of syphilitic nurses. Ernest Gallois. *Paris*, 1877.

3. On the non-transmissibility of syphilis by the medium of milk. De Amicis. *Annal. Clin. dello Osped. Incurab. An. II. Sept. and Oct. F. 5*, p. 278.

4. Two cases of transmission of syphilis by the male element of reproduction. Jordan. *Am. Four. of Obstet. Jan.* 1878, p. 126.

5. Investigation of the non-innuculability of the semen in syphilis. H. Mireur. *Ann. de Dermat. et de Syph. T. 8 No. 6*, p. 423.

6. Syphilis communicated by tattooing. Maury and Dulles. *Am. Four. of Med. Sci. Jan.* 1878, p. 44.

The conclusions are that milk does not in any way transmit syphilis—either when taken into the stomach or inoculated under the skin.

Jordan's article is dissected, and his cases declared worthless for scientific purposes.

Mireur's inoculation of four healthy persons with semen obtained from a syphilitic male with negative results, during six months of observation, are accepted as demonstrative that the semen does not contain the syphilitic virus in a form capable of propagation by inoculation.

A study of the fifteen cases where syphilis was communicated by tattooing shows that the saliva was only the vehicle of contagion, the true poison being furnished by the mucous patches in Kelly's mouth. *Chicago Med. Four. and Exam. Feb.* 1878, p. 145.

**A remarkable case of syphilitic inoculation.** In this case, by NEILL, vaginal secretions in a woman who had been syphilitic, but was apparently perfectly healthy at the time of intercourse are believed by Neill to have communicated chancre to his patient, although careful and repeated examination failed to detect any ulcer or abrasion at any point within the vagina of the woman. *Phil. Med. Times, Dec. 22*, 1877, p. 124.

**Two cases of syphilis in which the infection took place in unusual situations.** One of ROHÉ's cases was a chancre near the tip of the tongue, presumably communicated by putting a pencil into the mouth to wet it, after it had been similarly used by a young man having a "copious eruption on his face." Strangely enough this young man was not looked up, and the existence of his syphilis is only a matter of inference. The other case is a chancre of the lip upon a young man who remembers having kissed a young woman who had a sore lip. Here also there was no confrontation. The author refers to another case reported by him where syphilis had been communicated by a bite. *Chicago Med. Journal and Exam., July* 1878, p. 15.

**Important case of syphilitic infection.** BRAMBILIA's case is simply that of an infection upon the thumb of a midwife during the exercise of her calling. *Gaz. Medica Italiana Lom-*

*bardia*, No. 24, p. 231, 1877; *Annales de Dermat. et de Syph.*, No. 6, 1876-77.

**The virus of venereal sores; its unity or duality.** DR. BUMSTEAD's paper gives very little credit to the existence of any poisonous quality in chancroidal pus, and maintains that there is no specific chancroidal pus. *Trans. Inter. Med. Congress, Phil.*, 1877.

**Mammary chancres.** FOURNIER reports two cases, one of a phagedenic chancre, of peculiar severity, acquired in nursing. The other was a case of multiple chancre, twenty-three in all, seven on one nipple and areola, sixteen on the other, acquired from mucous patches in the mouth of a child. *Soc. Med. des Hôp., Gaz. des Hôp., Dec.* 1877.

**Chancre of the margin of the anus.** GOSSELIN's case was doubtless a chancroid, and possesses little interest beyond what a hysterical woman can give to her own case by intensifying her pains in their recital. Moreover Gosselin becomes obscure when he calls the lesion syphilitic in one breath, while in another he speaks about the danger of inoculation from the secretions. *Hôspit. de la Charité. Gaz. des Hôp., p.* 379, *April* 26, 1877.

**Two cases of indurated chancre observed in persons having formerly had syphilis.** In these cases of chancre, observed by MALHERBE after a previous attack of syphilis, there is abundant room to doubt whether the alleged ulcer was due to any infection, or was syphilis at all. There was no confrontation. In each case there was simply an indurated erosion on the penis without glandular enlargement, getting well in a few weeks under local treatment, and not followed by any general symptoms. *Four. de Med. de l'ouest. Gaz. des Hôp., p.* 862, *Sept.* 18, 1877.

**Indurated chancres occurring twice in the same person.** Two cases are reported by THEBAUD; one seems reliable, and to be a case of infection in a patient who had already been syphilitic. The second case is anything but convincing. *Hosp. Gaz., p.* 313, *Dec.* 1, 1877.

**Indurated chancres in subjects previously affected with syphilis.** Two cases are given by LEMAIRE: one is evidently a case of second infection, the other is doubtful. Another case, reported by Anthony in the *Gaz. des Hôp., Oct.* 20th, is referred to. *Gaz. des Hôp., p.* 1088, *Nov.* 17, 1877.

**On the excision of the initial lesion of syphilis.** AUSPITZ has worked up his 33 cases of excision very creditably, but his conclusions are far from convincing. Ten of these cases he withdraws in summing up, on various grounds: either because it was doubtful whether the patients had general syphilitic symptoms or not, because they already had general symptoms before the local lesion had been excised, or because they could not be carefully observed for a sufficiently long period after excision. Of the 23

remaining cases, 9 are frankly allowed to have had symptoms of general syphilis after excision, while in 14 it is claimed that no general symptoms followed.

The weak points in these 14 cases as shown in their histories are (1) that no attempt is made at accuracy as to the period of incubation of the alleged chancre. (2) No confrontations were made to establish the diagnosis. (3) Some of the 14 cases undoubtedly did have general symptoms of syphilis, as their histories show. (4) Several of the cases were observed only during a few months. (5) The diagnosis was made to rest upon the objective characteristics of the ulcer and its induration alone. Some of the cases do certainly sound in the reading as if the patient had syphilis, and was saved from general infection by the extirpation of his local sore—which was very carefully done in all cases.

It is to be regretted that the omissions noted above exist, since they deprive the paper very considerably of its otherwise great value.

Auspitz concludes that the excision of chancre induration saves the patient from syphilis sometimes, and at other times modifies the severity of the general symptoms, and this even when the extirpation is undertaken after the inguinal glands have already become characteristically indurated. Auspitz advises that all chancre indurations which can be entirely and cleanly extirpated by one sweep of the curved scissors—as, for example, chancres of the prepuce—be so extirpated, and following the advice can certainly lead to no harm, even if the attempt fails to avert general symptoms. *Viertelj. f. Derm. u. Syph., Heft. I. & II., p. 107.*

**The anatomy of the initial induration of syphilis.** AUSPITZ and UNA believe that besides the thickening of the arterial coats, infecting chancre (as contradistinguished from chancroid) is characterized by an increase in the fibrous elements of the skin, a lack of true ulceration, a preservation of the epidermis, which grows inwards and throws out lateral processes. There are also great numbers of wandering cells. The coats of the lymphatic vessels are slightly thickened. *Vierteljahreschrift f. Derm. u. Syph., Heft. I. & II., p. 161.*

**The general pathology of syphilis.** CORNIL, relying mainly upon the report of Auspitz and Una (reviewed above), declares his inclination toward a belief that infecting chancre is not an evidence of general infection, but only the point of entrance, and that the system does not become generally infected until after the chancre has existed—he does not say how long. *Le Prog. Med., May 25, 1878, p. 396, and June 29, 1878, p. 501.*

**Syphilis acquired late in life.** SIGMUND obtains the 118 cases upon which this article is based from a 30 years' practice in hospital and private life; of these, a slight majority were private patients. By late in life, Sigmund means women over 45, men over 55. One of the peculiarities noticed in old people was that

the incubation, development, and progress of the initial and subsequent lesions is slower relatively in advanced life than in youth. The influence of specific treatment seems also to be slower in establishing itself. A continuation of the article is promised, giving Sigmund's experience as to the course and treatment of syphilis late in life. *Wien. Med. Wochen.*, May 25, 1878, p. 562.

**Certain relations between syphilis and cancer.** HUTCHINSON, at the forty-sixth meeting of the British Medical Association, stated that although in his opinion the syphilitic dyscrasia was not a cause of cancer, yet the local irritation of syphilitic sores might induce a cancerous action in the part affected. Dr. Tibbets believed there was an intimate relation between syphilis and cancer, tubercle, adenoma, and Addison's disease. In the case of cancer the generative organs were often affected. Drs. Walker, G. Jackson, Lennox Browne, and W. Rivington concurred generally in the main proposition. *British Medical Journal*, August 24, 1878, p. 282.

**On the so-called pigmentary syphilide.** DR. GEORGE H FOX believes that the pigmentary syphilide is a non-specific vitiligo, occupying the site of a previous syphilide. He considers that the whitish macules constitute the most important feature of the affection, and believes them to be white on account of a local loss of pigment. He does not consider all the whiteness due to the hyper-pigmentation of the surrounding integument.

From close study of a case reported, he concludes that the white macules occupy the sites of pre-existing syphilitic lesions, which latter may sometimes be observed as dark central points.

He cites a case to prove that the commonly received opinion that the pigmentary syphilide is confined to fair skinned persons is erroneous. *Amer. Journ. Med. Sciences*, p. 359, April, 1878.

**Syphilitic Pneumonia.** DR. SACHARJIN (basing his conclusions upon two personal cases) believes that pure, uncomplicated syphilitic pneumonia may be distinguished from ordinary phthisis by the following characters: 1. Syphilitic history; 2. The strong constitution of the patient; 3. Objective evidences of thickening of the lung tissue; 4. Absence of cough, sputa, râles and hæmoptysis; 5. Absence of fever; 6. Prompt action of mercury in small doses. *Berliner Klin. Wochensch.*, Jan. 21, 1878, p. 35.

**Notes on syphilitic phthisis.** DR. FREDERICK ROBINSON believes there are two forms of lung affection due to syphilis. In the first, which is less common than the other, the disease appears primarily at the base of the lung posteriorly, and extends upwards, posteriorly and anteriorly, to the apex. In the second form one apex is involved; sometimes both. In either case the patient is apt to appear free from syphilitic disease elsewhere, having passed through the secondary stage.

The first mentioned form he believes does not differ materially

from ordinary chronic pneumonia. There is very little pyrexia, dyspnœa only on exertion at first, and no sputa.

The second form is apt to be mistaken for ordinary chronic tuberculosis, affecting one or both apices.

Robinson formulates the following four points of difference. In syphilitic disease: 1. The patient does not look phthisical; the chest is well developed, the body is well nourished. 2. There is no diarrhœa, no night sweat, irritation, cough; but little rise in temperature. 3. Dullness on percussion is less marked, its area less definable. Both apices are frequently affected simultaneously. 4. Patient is pallid and cachectic, but has no tubercular sputa. Respiration is harsh, perhaps tubular; few, if any, moist râles. *London Lancet*, May 5th, 1877, p. 638.

**On syphilitic phthisis.** Dr. R. E. THOMPSON, agreeing in the main with previously published descriptions by Dr. Robinson and Dr. Shepherd, believes that in syphilitic phthisis dyspnœa is always a chief cause of complaint, and is much aggravated in going up hill or up stairs. Expectoration, sometimes slight, may be profuse, if the bronchial tubes are involved. Hæmoptysis he believes to be common, slight hemorrhage frequently recurring. Cachexia generally present. Respiratory sound is harsh; râles generally absent; no crepitation; dullness on percussion, generally at apices.

Thompson thinks well of large doses of the iodide of iron in the treatment of syphilitic phthisis. *Lancet*, p. 386, *Sept.* 15, 1877; p. 528, *April* 13, 1878.

**Cardiac syphilis.** Twenty-four cases form the basis of GRENOUILLER'S Thesis, collected mainly from French, English and German authors. Grenouiller agrees with Lebert, Ricord and Virchow as to the existence of a syphilitic endocarditis. The muscular tissue of the heart, however, is by far the most often involved. Syphilitic myositis, terminating nearly always in fibrous sclerosis, starts as a small gumma, analogous to gummata of other organs.

Virchow, Lancereaux and Hutchinson believe in the existence of a diffuse generalized myositis, without tumor. This myositis differs from that seen in rheumatism and chronic alcoholism by the quantity and the hardness of the fibrous proliferations it gives rise to. Gummata of the heart are very common. Eighteen gummata were found in the twenty-four patients. They have been observed in the first year after infection. The wall of the left ventricle seems to be their most common seat.

The study of symptoms during life is far from complete. In most of the patients an affection of the heart was suspected, but auscultation did not allow any precise diagnosis to be reached. Sudden death was the most common termination (two thirds of the cases about.) Cerebral complications were not uncommon. As to treatment. In two cases in which Lancereaux suspected

syphilitic disease of the heart, anti-syphilitic, treatment gave good results. *Thèse de Paris*, 2878. *Lyon Méd.*, June 30, 1878, p. 315.

**Syphiloma of the heart.** DR. S. SMITH reports a case of gummy tumor of the left ventricular wall of the heart in an apparently healthy woman, leading to sudden death. No treatment had been used, and no disease, apparently, suspected. Dr. Smith showed microscopic preparations of the specimen—a coarse, fibrous stroma, resembling the normal stroma of the heart much thickened, universally infiltrated with an abundance of small cells. Bristol. Medico Chirurg. Soc. *Lancet*, p. 240, Feb. 16, 1878.

**The occurrence of splenic tumor in recent syphilitic infection.** WEBER states that seventy-five per cent. of syphilitic patients have an enlargement of the spleen, due to the disease, which may be detected from eight to twelve weeks after infection, from one to two weeks after the appearance of general symptoms. It usually continues from four to eight weeks, and is favorably influenced by a mercurial course. *Deutsch. Arch. f. Klin. Med.*, 4, 5, 1879. *N. Y. Med. Journal*, p. 660, June, 1877.

**Syphilitic stricture of the rectum.** TRÉLAT in his article, "Rectum," in the Dict. Encycl., 1874, asserts that syphilitic stricture is always a neoplastic exudation of special nature, differing from gumma, and attacking the tunics of the rectum consecutively, not far above the anus. The case now reported confirms him in these views. He thinks that multiple dry fistulæ, starting below the point of stricture, are almost pathognomonic of syphiloma of the rectum. These fistulæ cicatrize almost as soon as they form. He differs with Fournier in admitting surface ulceration, but does not believe that cicatrization has any causal relation to syphilitic stricture. He therefore insists that active anti-syphilitic treatment is valuable even in the late stages of the malady. Fournier claims that treatment is only successful if commenced early, useless after the degenerative fibroid change has reduced the stricture to the condition of a cicatrix. Trélat's treatment is mercury and iodine internally, glycerine and mild astringents locally, and section of the stricture with the galvano-caustic wire in cases of tight coarctation. *Reported by Marot in Le Prog. Méd.*, Sept. 15, 1877, p. 710, and *Le Prog. Méd.*, June 22, 1878, p. 473.

**Arterial lesions in syphilis.** LANCEREAUX believes that the alterations produced by syphilis in the arterial walls have the anatomical peculiarity of being isolated, circumscribed. Thus the patches of arteritis rarely attain the length of one or two centimeters. They commence in the internal non-vascular arterial tunic as slight elevations, like atheromatous patches. When these little patches open into the vessel, slight cavities remain, little aneurisms. Lanceriaux showed several of these to the Association. Sometimes these aneurisms attain considerable development. Sometimes the arteritis goes on to an obliteration of the artery.

The differential signs of this malady, with atheroma, are:—

1. Syphilitic history; 2. Cerebral arteries involved more often than the aorta and larger vessels, where atheroma is habitually found; 3. The comparative youth of a majority of the patients; 4. A certain tendency to symmetry in the lesions (doubtless he refers here to the revelations of the autopsy.) *Assoc. française pour l'avancement des sciences. Le Prog. Méd., p. 676, Sept. 1, 1877.*

**Syphilitic arteritis.** BAUMGARTEN opposes Friedlander's view that the growth in the lumen of arteries in obliterative arteritis is due solely to wandering cells from the vasa vasorum. He believes it mainly due to proliferation of cells in the epithelial layer. The growth in and about the adventitia, he admits, presents the histological character of gumma, and consequently he believes it to be specifically syphilitic. Not so the endo-arteritis, since the tissue formed within the vessels is the same in non-specific obliterative disease. *Virchow's Archiv., Bd., LXX., Heft. I. London Med. Record, July 15, 1878, p. 294.*

**Syphilitic separation of the epiphyses.** O. HAAB's article advances our knowledge as to the minute pathological changes which transpire in the epiphyseal extremities of the long bones of children having inherited syphilis, changes which culminate in a separation of the epiphysis from the diaphysis.

His researches are of especial interest, since they differ in result from what had been advanced by Wegner, as well as from what Waldeyer and Koebner put forth later as the essence of the same pathological process.

Wegner (*Virch. Archiv. Bd. L. S., 305*), looked upon the syphilitic process, which terminated in epiphyseal separation as an osteochondritis. He located the beginning of the trouble in the cartilage, believing that the vessels were cramped by a too rapid deposit of bone salts on the one hand, while the cartilage cells increased too rapidly on the other. Thus arose a stagnating layer, constantly increasing in extent between the proliferating zone of the cartilage and the medullary prolongations in the diaphysis. This layer fell into a sort of suppuration with the formation of granulations, and ended in a separation of the epiphysis, like the throwing off of a sequestrum.

Waldeyer and Koebner, on the other hand (*Virch. Archiv., Bd. LV., S., 367*), looked upon the process more as a formation of granulation tissue of syphilitic character, growing out from the medullary prolongations and into the cartilage.

From a study of two cases Haab concludes that the process of separation takes place in the cartilage, about at the line of junction of the proliferating with the hypertrophic layer. He thinks that there are two grades in the process, the one milder and degenerative, the other more irritative—more of a syphilitic chondritis.

The first form was well demonstrated by his first case. A brown molecular degeneration of the intercellular cartilaginous



substance, the cells being for the most part spared, resulted in the disintegration of the cartilage above the hypertrophic layer, by the formation of a fine split, which went on to an entire separation of the epiphysis, the bone, the periosteum and the rest of the structures being absolutely spared.

In the irritative type of malady (the second case) there was active proliferation of cartilage cells, besides the brownish molecular degeneration of the intercellular substance, and a growing forward of the medullary prolongations. These two processes culminated in a separation of the epiphysis. *Virch. Archiv., LXV., p. 366.*

**The abortive treatment of syphilis.** WEISFLOG makes the very serious assertion that for the last five years he has been uniformly successful in aborting syphilis—preventing the appearance of general symptoms when a patient had indurated chancre. The article, however, which makes the announcement, does not contain evidence of such a character as to carry conviction. Its arguments are theories. It lacks details on all important points. The process consists in a subcutaneous injection of a watery solution of the nitrate of mercury (“des salpetersauren quecksilberoxyduls,”) in the region between the chancre and the inguinal glands—but the author does not consider it worth while to mention the strength of the solution. The *modus operandi* is, therefore, hardly worth detailing. *Virchow's Archives LXIX, 1, p. 143, 1877, Schmidt's Jahrb., June 13, 1878, p. 39.*

**Summary of cases of syphilis treated without mercury.** BOILEAU's article, read before the British Medical Association, forty-sixth meeting, contains no fact worthy of record and no statistics, simply a statement that all his patients got well while taking baths, rest, iodide of potassium, Dover's powder, nitrate and chlorate of potash, etc. *British Medical Journal, August 24, 1878, p. 282.*

**Abortive treatment of bubo.** CONWAY speaks of the abortive treatment of bubo, which he communicates to the *Lancet* as “Malplaquet's discutient plan.” The cuticle over the swelling is removed by blistering fluid to the extent of a shilling piece, lint soaked in a saturated solution of perchloride of mercury, is put upon the raw surface and retained there by a linseed poultice during twenty-four hours. Sharp pain is felt for a short time, a greyish eschar forms, this comes off after two to three days poulticing, and while the shallow depression is granulating, the bubo disappears. Twelve cases are referred to and the result praised in all.

This method in its essence is an old one, and the doctor fails to allude to the possibility of harm, if a cure by this method was attempted in a case of virulent bubo. *Lancet, p. 159, August 4, 1877.*

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## Reviews and Book Notices.

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*Lectures on Clinical Surgery.* By Jonathan Hutchinson, F.R.L.S. Vol. I., Part I. On certain rare diseases of the skin. London. Churchill, 1878, pp. 192.

It is unfortunate for dermatology that certain writers still persist in claiming diseases of the skin as a part of general surgery, for there is no branch of medicine in which less manual (surgical) interference is necessary on the part of the physician. Dermatology is essentially a medical branch, and the more the connection and relations of diseases of the skin to other organs are studied, the more will the science be advanced, and the art be perfected.

Mr. Hutchinson's volume is a valuable contribution to dermatology, because it is the careful and conscientious work of a very able observer and clear writer; with large clinical experience; but it is unfortunate, at the time when observers are endeavoring to simplify the subject by adhering to a nomenclature with a basis which can become universal, that an author of Mr. Hutchinson's prominence should introduce and perpetuate such names as *varicella-prurigo*, *acne-prurigo*, *lichen-prurigo*, *eczema-prurigo*, *lichen-eczema*, which all appear in the book before us, to say nothing of such combinations as *lupus-psoriasis*, *cheiro-pompholix*, etc., which appear elsewhere.

Mr. Hutchinson seems rather to despair at having dermatology simplified so that the ordinary practitioner can grasp it, and devotes a lecture to an excuse for this hybridization of dermatological terms; but we must confess that the tendency of writers to meddle with nomenclature and classification, which prevailed so largely in the past, has done much to mystify a subject which otherwise need not present such insurmountable difficulties as are claimed for it.

We have not space to review in detail this interesting book, in which are lectures upon *molluscum contagiosum*, *varicella-prurigo*, *leucoderma*, *pemphigus*, *prurigo*, diseases of the nails, *ichthyosis*, and *sudamina*. Several of these lectures have appeared previously in the weekly journals, and we welcome the volume both for these and for the new matter contained. The author still applies the term *prurigo* instead of *pruritus* to itchy states of the skin, describing under the name of *winter prurigo* the affection so clearly portrayed by Duhring some years ago as *pruritus hiemalis*, and he fails to recognize the distinctive features of Hebra's *prurigo* in a degree sufficient to admit of confining the name *prurigo* to it. He says, "As the result of careful inquiry, extending over many

years, I am unable to identify any cases that will fit exactly with the Vienna description of prurigo." Now, no one who remains in Vienna any length of time can fail to be impressed most vividly with the characteristics of Hebra's prurigo, as was the writer on a recent second visit, after an interval of nearly ten years from the first acquaintantance with and study of the disease. That the disease prurigo, in the sense in which the term is used by Hebra, exists in America, there can be no doubt, although the cases are very rare.

Mr. Hutchinson promises another part to complete this volume on certain rare diseases of the skin, to which we shall look forward with pleasure. It would much enhance the value, as well as the pleasure of reading contributions to dermatology if writers could and would adopt an uniform nomenclature and classification. At the last meeting of the American Dermatological Association a scheme was presented which, though yet far from perfect, will, it is hoped, do something towards unifying dermatological thought in America. We wish, most heartily, than an international commission could confer on the subject, and form a basis on which uniformity of language would rest for writers in different countries.

*Atlas of Skin Diseases, consisting of a Series of Colored Illustrations, together with Descriptive Text and Notes upon Treatment.* By Tilbury Fox, M. D., F. R. C. P. Physician to the Department for Skin Diseases, University College Hospital. Philadelphia. Lindsay & Blakiston, 1876, parts VI.—XII.

In reviewing the first five parts of this Atlas in a previous issue, we remarked that we thought that Dr. Fox had made a mistake in basing his work upon that of Willan and Bateman, of which it is largely a reproduction, for while the latter was a marvel for the time of its issue, and did much to advance the knowledge of skin diseases, the light which shines upon Dermatology at the present day throws the works of a former age quite in the shadow.

Of the twenty-eight plates in these fasciculi twelve are new, taken either from living cases or previous drawings; they represent the Impetigo contagiosa of Dr. Fox, Psoriasis, Pityriasis rubra, Lichen ruber, Prurigo ferox, and lupus, and are good additions to the work, as the affections were neglected in the original work.

We regret that Dr. Fox has retained so many of the old names, and some of very questionable meaning; thus one plate represents "bakers' or grocers' itch," another "impetigo rodens," another "porrigo," names which have long ceased to pass current in scientific dermatological nomenclature. There is an inexcusable mis-printing of the covers of some of these fasciculi, whereby the real contents are seen to be entirely different from those ascribed to the various plates on the cover. This however would be rectified in binding.

The portion of the work which belongs properly to Dr. Fox,

namely, the letter press, is very good, and anyone who follows his clear and practical directions, with a fair amount of common sense, will cure his cases, while a perfect acquaintance with these plates will very materially assist him in arriving at the correct diagnosis.

*Atlas of Skin Diseases.* By Louis A. Duhring, M. D. Professor of Skin Diseases in the Hospital of the University of Pennsylvania, etc. Part IV. Philadelphia. J. B. Lippincott & Co., 1878.

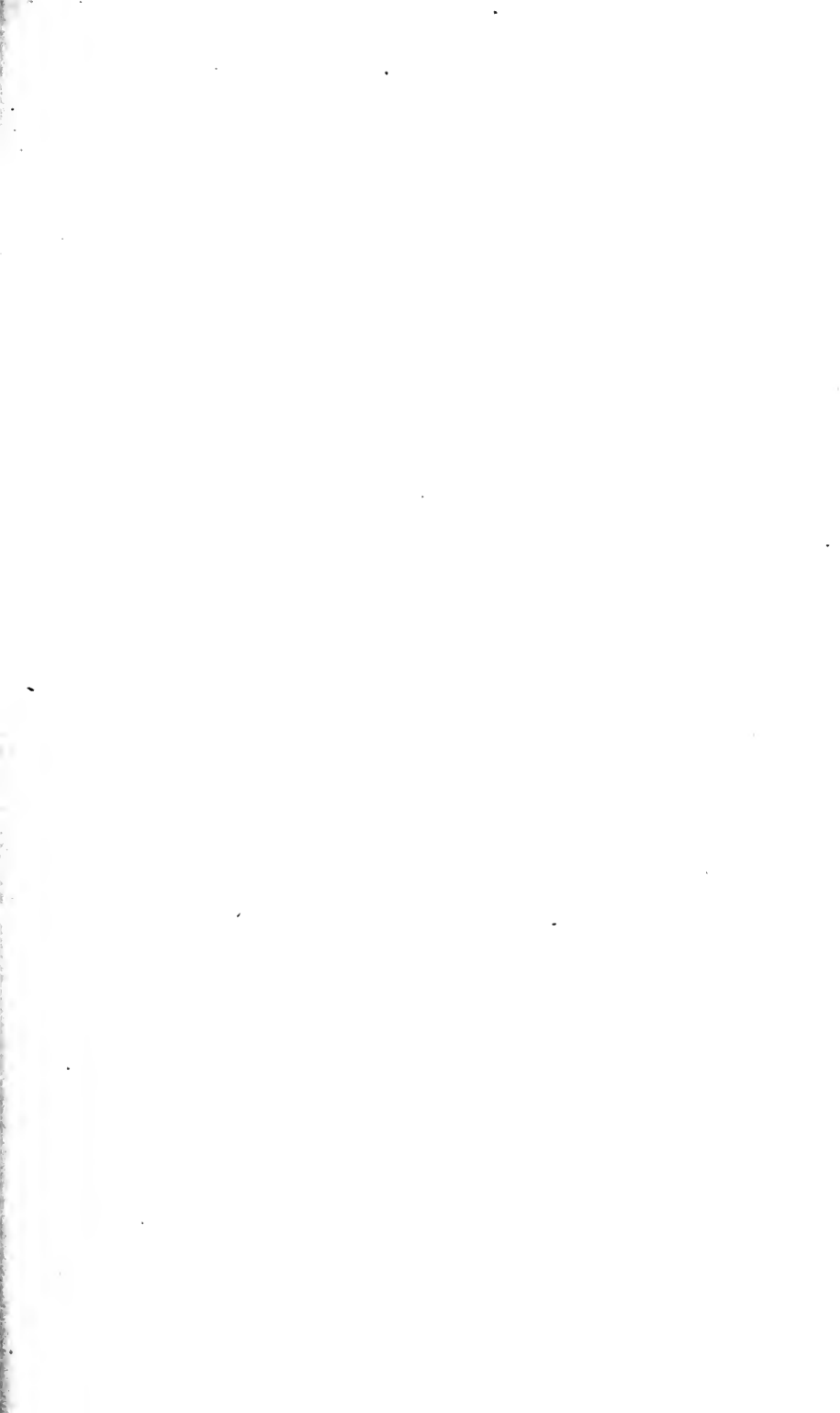
Our readers are aware of the excellencies of this atlas in the course of publication: Part IV., containing representations of Vitiligo (leucoderma) Alopecia areata, Tinea favosa and Eczema (rubrum), fully maintains the high standard of work exhibited in former fasciculi, and confirms what has been said in regard to preceding parts.

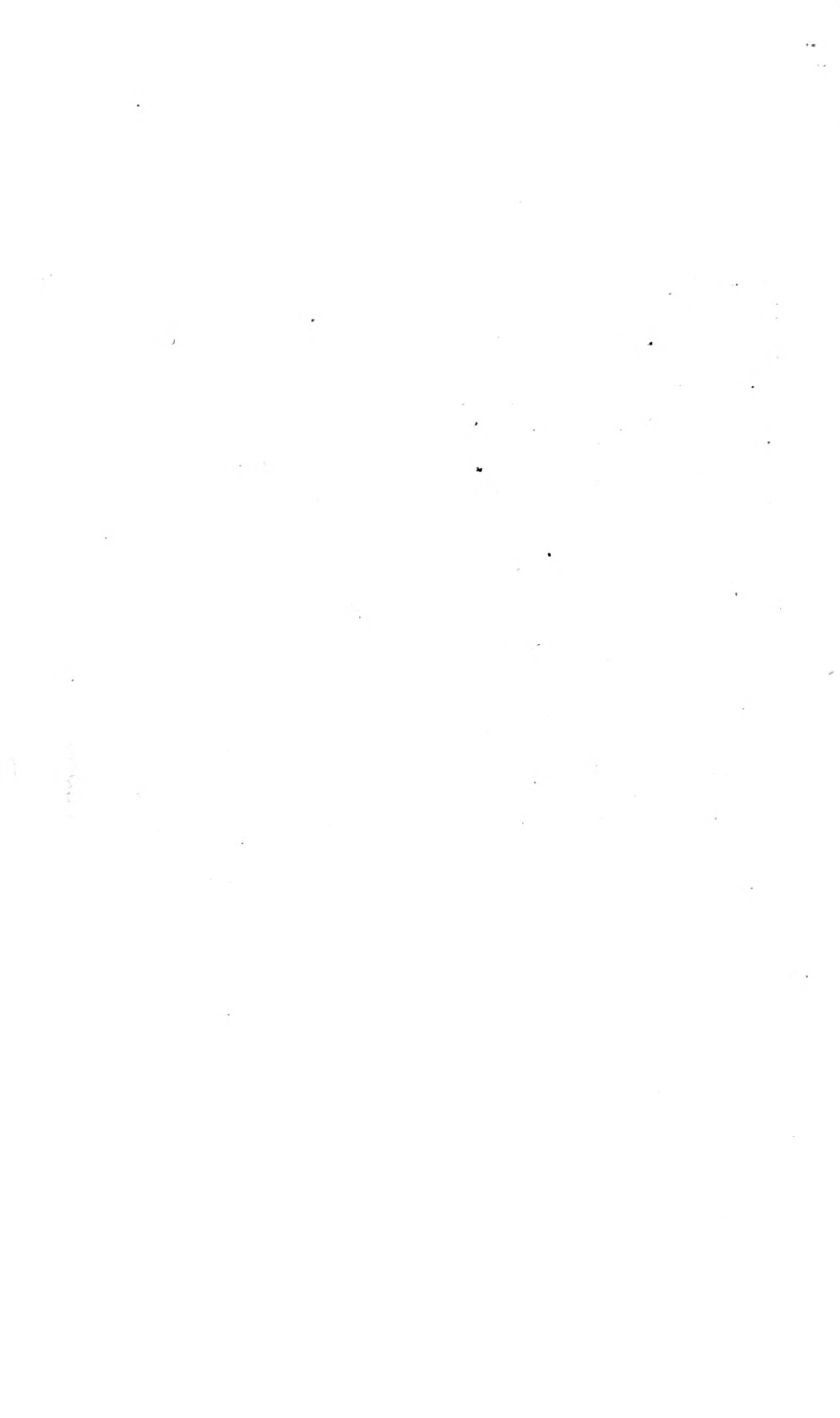
The text is admirably written, and with it and the plates the practitioner will be able to diagnose even these more rare affections of the skin. The work is slow in appearing, several months having elapsed since this part appeared; but few can understand the difficulties of the work, and it is far better to have the work thus well done, than to have an imperfect one hurried through the press. Dr. Duhring's work is one that will long remain classical.

(In order to give space to our full report of the proceedings of the Second Annual Meeting of the American Dermatological Association, a large quantity of matter prepared for this issue has been crowded out—especially in the department of Digest of Literature. We have also been obliged to defer the publication of the Index and title page for this volume, until the next issue of the Journal.—EDITOR.)











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